**Dr. Japera Levine D.P.M.**

350 Pine St. Suite 1420

Downtown Beaumont

**Patient Information Form**

**Please Print-Mark “N/A” If It Does Not Apply To You**

**ALL FIELDS ARE MANDATORY**

 Date of Service:

Full Name: Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

Gender: \_\_\_ Male \_\_\_ Female Social Security#: \_\_\_\_-\_\_\_-\_\_\_\_\_ Shoe Size: \_\_\_\_\_\_\_

Race: \_\_\_ American Indian/Native \_\_\_ Asian \_\_\_Black/African American \_\_\_Caucasian/White

 \_\_\_ Hispanic/Latino \_\_\_Hawaiian/Pacific Islander

Home Phone/Alternate Number: Cell Phone:

Mailing Address:

 Street Address City Zip

Marital Status: \_\_\_Child \_\_\_Single \_\_\_Married \_\_\_Separated \_\_\_Divorced \_\_\_Widowed

Employer: Title/Occupation:

Pharmacy: Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name (Not Living In The Your Home):

Relation: Phone:

Primary Care Physician: Phone:

When Did You Last See Your PCP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Management Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When Did You Last See Your Pain Management? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who Referred You? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible For Payment (Full Name): Date Of Birth: SSN:

Insurance 1st: Policy #:

Policy Holder & Relationship: Group#:

Date Of Birth: SSN:

Insurance 2nd: Policy #:

Policy Holder & Relationship: Group#:

Date Of Birth: SSN:

Is This Workers Comp? \_\_\_Yes \_\_\_No

REASON FOR VISIT TODAY? **BE SPECIFIC** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PEDIATRIC PATIENTS ONLY:**

Is Your Condition Getting Better/Worse? Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does The Problem Involve Both Sides Of The Body? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is There Leg Or Foot Pain In Rest And/or With Certain Activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Current Or Past Treatment For Leg Or Foot Pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, Were There Any Successful Treatments For Them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Significant Medical Problems: Including Medications, Trauma, Or Surgery Involving The Mother During The Time Of The Pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Significant Issues During Delivery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did You Have Any Issues Meeting Any Of Developmental Milestones At The Appropriate Time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Have Any Issues With School, Speech, And Learning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From A Parent’s Perspective Have You Ever Been Concerned At All With Any Part Of Your Child’s Lower Extremity/Type Of Walk/Look Of Feet Prior To Today’s Visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Your Child Have Any Issues With Fatigue, Endurance, Speed, Posture, Or General Strength? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History- Please List Any Medical History That Your Family May Have That May Or May Not Be Foot Related:**

**Relation To Patient: List RELATED History Below: Living Or Deceased:**

|  |  |  |
| --- | --- | --- |
| Father |   |  |
| Mother |  |  |
| Spouse |  |  |
| Son/Daughter- Circle One |  |  |

**Patient’s Medical History-** Please Circle “Y” For Yes/“N” For No

|  |  |  |
| --- | --- | --- |
| Acid Reflux Y/N | Fibromyalgia Y/N | Open Sores Y/N |
| Anemia Y/N | Gout Y/N | Pneumonia/Vaccine Y/N |
| Arthritis Y/N | Heart Attack Y/N | Polio Y/N |
| Asthma Y/N | Heart Disease Y/N | Heart Failure Y/N |
| Back Trouble Y/N | Hepatitis Y/N | Sickle Cell Disease Y/N |
| Bladder Infections Y/N | Hiv/Aids Y/N | Skin Disorder Y/N |
| Abnormal Bleeding Y/N | High Blood Pressure Y/N | Sleep Apnea Y/N |
| Blood Clots Y/N | Kidney Disease Y/N | Stomach Ulcers Y/N |
| Blood Transfusion Y/N | Liver Disease Y/N | Stroke Y/N |
| Bronchitis Y/N | Low Blood Pressure Y/N | Thyroid Disease Y/N |
| Cancer Y/N | Migraines/Headaches Y/N | Tuberculosis Y/N |
| Diabetes Y/N | Mitral Valve Prolapse Y/N | Influenza Vaccine Y/N |
| Weight Loss Surgery Y/N | Keloids Y/N | Neuropathy Y/N |
| Other:  | Other:  | Other: |
| Other:  | Other:  | Other: |
| **\*\*\*\*** Value & Date of your last **hemoglobin a1c**? |

**Patient’s Social History**

Use Of Alcohol- Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Social \_\_\_Occasional \_\_\_Light \_\_\_Heavy \_\_\_Never

Use Of Tobacco: \_\_\_\_ Never \_\_\_ Smoke \_\_\_ Quit – How Long Ago? \_\_\_\_\_\_\_ Would you like to quit smoking? \_\_\_\_\_

Have you tried to quit smoking previously? \_\_\_\_\_ How many times have you tried to quit smoking? \_\_\_\_\_

Use Of Recreational Drugs: \_\_\_ Never \_\_\_ Current Use Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Quit – How Long Ago? \_\_\_\_\_

How Much Are You On Your Feet At Work? \_\_\_10% \_\_\_25% \_\_\_50% \_\_\_75% \_\_\_100%

Do Others Depend Upon You For Their Care? \_\_\_Children–AGE (S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_PET (S)–What Kind? \_\_\_\_\_\_\_\_ \_\_\_ Elderly Or Disabled Family Member

 \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise:** \_\_\_Never \_\_\_Rare \_\_\_Occasional \_\_\_Weekly \_\_\_Several Times A Week \_\_\_Daily

Types Of Exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Surgical History**

 **Type Of Surgeries** (Please List Right Or Left) **Year**

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**Review Of Systems- Please Check All That Apply**

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| --- | --- | --- |
| **CONSTITUTIONAL:**  | **URINARY:**  | **Breast:** |
| Chills Y/N | Awakening To Urinate Y/N | Discharge Y/N |
| Fever Y/N | Burning Y/N | Lumps Y/N |
| Weight Loss/Gain-**Circle One** Y/N | Flank Pain Y/N | Tenderness Y/N |
| Weakness Y/N | Infections Y/N | Pain Y/N |
| Fatigue Y/N | Stones Y/N |  |
|  | Urine Odor Y/N | **Skin:** |
| **Head:** | Bed-Wetting Y/N | Dryness Y/N |
| Dizziness Y/N | Difficulty Starting Stream Y/N | Itching Y/N |
| Fainting Y/N | Frequency Y/N | Nail Appearance Change Y/N |
| Pain Y/N | Urgency Y/N | Skin Color Change Y/N |
| Head Injury Y/N | Blood In Urine Y/N | Easily Bruised Y/N |
| Sweats Y/N | Excessive Urination Y/N | Hair Texture Change Y/N |
|  | Incontinence Y/N | Nail Texture Change Y/N |
| **Eyes:** | Retention Y/N | Eczema Y/N |
| Blurry/Double Vision Y/N | Urine Discoloration Y/N | Mole Increased Size Y/N |
| Eyeglass Use Y/N |  | Rashes Y/N |
| Pain W/ Light Y/N | **Cardiovascular:** |  |
| Unusual Sensation Y/N | Chest Pain Y/N | **Neurological:** |
| Cataracts Y/N | Hair Loss On Legs Y/N | Blackouts Y/N |
| Excessive Tearing Y/N | Swelling Of Legs Y/N | Fainting Y/N |
| Glaucoma Y/N | Varicose Veins Y/N | Loss Of Consciousness Y/N |
| Recent Injury Y/N | Cold Extremities Y/N | Paralysis Y/N |
| Vision Loss Y/N | Heart Murmur Y/N | Tingling Y/N |
| Discharge Y/N | Thrombophlebitis Y/N | Burning Y/N |
| Eye Pain Y/N | Discolored Extremities Y/N | Speech Disorder Y/N |
| Infections Y/N | Heart Tests Y/N | Tremors Y/N |
| Redness Y/N | Rheumatic Fever Y/N | Numbness Y/N |
|  | Ulcer On Legs Y/N | Unsteady Gait Y/N |
| **Nose:** | Palpitations Y/N |  |
| Discharge Y/N |  | **Endocrine:** |
| Sinus Infections Y/N | **Gastrointestinal:** | Cold Intolerance Y/N |
| Frequent Colds Y/N | Change In Stool Color Y/N | Goiter Y/N |
| Nasal Obstructions Y/N | Decreased Appetite Y/N | Neck Pain Y/N |
| Nosebleeds Y/N | Excessive Thirst Y/N | Weakness Y/N |
|  | Hemorrhoids Y/N | Heat Intolerance Y/N |
| **Ears:** | Jaundice Y/N | Fatigue Y/N |
| Discharge Y/N | Nausea Y/N | Increased Thirst Y/N |
| Hearing Impairment Y/N | Swallowing Problem Y/N |  |
| Ringing In Ears Y/N | Change In Frequency Of Bm Y/N | **Allergic/Immunologic:** |
| Infections Y/N | Diarrhea Y/N | Coughing Y/N |
| Hearing Aid Y/N | Gallbladder Disease Y/N | Itchy Eyes Y/N |
| Pain Y/N | Laxative Use Y/N | Runny Nose Y/N |
|  | Rectal Bleeding Y/N | Watery Eyes Y/N |
| **Throat/Neck:** | Vomiting Y/N | Coughing W/ Exercise Y/N |
| Sore Throat Y/N | Antacid Use Y/N | Itchy Nose Y/N |
| Enlarged Tonsils Y/N | Constipation Y/N | Sneezing Y/N |
| Lumps Y/N | Excessive Hunger Y/N | Wheezing Y/N |
| Tenderness Y/N | Heartburn Y/N | Hives Y/N |
|  | Infections Y/N | Recurrent Infections Y/N |
| **Respiratory:**  | Rectal Pain Y/N | Stuffy Nose Y/N |
| Coughing Blood Y/N | Vomiting Blood Y/N | Wheezing W/ Exercise Y/N |
| Sputum Y/N | Abdominal Pain Y/N |  |
| Pain Y/N |  | **Psychiatric:** |
| Cough Y/N | **Musculoskeletal:** | Behavioral Changes Y/N |
| Shortness Of Breath Y/N | Restricted Motion Y/N | Disturbing Thoughts Y/N |
| Palpitations Y/N | Joint Pain Y/N | Memory Loss Y/N |
| Exertion Y/N  | Muscle Stiffness Y/N | Psychiatric Disorders Y/N |
|  | Weakness Y/N | Depression Y/N |
| **Hematological/Lymph:** | Deformities Y/N | Excessive Stress Y/N |
| Swollen Glands Y/N | Joint Stiffness Y/N | Mood Changes Y/N |
| Bleeding Easily Y/N | Paralysis Y/N | Disorientation Y/N |
| Lumps Y/N | Muscle Cramps Y/N | Hallucinations Y/N |
| Transfusion Reaction Y/N |  | Nervousness Y/N |
| Blood Clots Y/N | **Females**: Are you Pregnant? y/n |  |
| Radiation Exposure Y/N |  |  |

**Please List All Medications You Are Currently Taking**-Include Prescriptions, Otc Meds And Herbal Supplements

 Name Of Med DOSE (Mg/Ml/Mcg) HOW Often Do You Take It?

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**Please List True Allergies Only & Your Reaction To Each Allergy:**

Allergies (What Are You Allergic To): Reaction (What Happens):

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To The Best Of My Knowledge, I Will Answer The Questions On These Forms Accurately. I Understand That Providing Incorrect Information Can Be Dangerous To My Health. I Understand That It Is My Responsibility To Inform The Doctor And Office Staff Of Any Changes In My Medical Status. Dr. Japera N. Levine DPM PLLC Offers Her Patients The Opportunity To Communicate By E-Mail. This Form Provides Information About The Risks Of E-Mail, Guidelines For E-Mail Communication And How We Will Use E-Mail Communication. It Also Will Be Used To Document Your Consent For Us To Communicate With You By E-Mail By Instructing You On How To Setup Your Patient Portal.

 Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

person filling out document if different from the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent For Photography, Videotaping, Or Other Imaging For Media/Educational Purposes**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Japera Levine Typically Takes Pictures Of Each Patient To Help Educate The Patient As Well As Other Patients’ Who May Have A Similar Condition. Dr. Levine’s Office Strictly Uses Pictures & Videos; We Will Keep Each Patient’s Information Confidential. If You Agree Please Initial & Sign Below.

I Give My Consent To Have Photographs, Videotaped Images, Or Other Images Made Of **My Medical Condition & Myself**. I Understand And Agree That These Images May Be Used By Dr. Japera N. Levine DPM PLLC At **Any** Time For The Purpose (S) Outlined Below Without Compensation.

\_\_\_\_\_ Teaching Purposes (May Include Being Shown To Other Patients)

\_\_\_\_\_ Advertisements By Dr. Japera N. Levine DPM PLLC

\_\_\_\_\_ Placement On Dr. Japera N. Levine DPM PLLC’S Website- drjlevinedpm.com

\_\_\_\_\_ Placement On Dr. Japera N Levine DPM PLLC’S Office Social Media- FB: Dr. Japera N. Levine/

 SC: Dr. JLevine/IG: Dr. JNLevine

\_\_\_\_\_ Continuing Medical Education Or Board Certification Examinations

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Of Patient/Parent/Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail Consent/Agreement**

 Risks

 Communication By E-Mail Has A Number Of Risks That Include, But Are Not Limited To, The Following:

* E-Mail Can Be Circulated, Forwarded, And Stored In Paper And Electronic Files.
* Backup Copies Of E-Mail May Exist Even After The Sender Or The Recipient Has Deleted His/hers Copy.
* E-Mail Can Be Received By Unintended Recipients.
* E-Mail Can Be Intercepted, Altered, Forwarded, Or Used Without Authorization Or Detection.
* E-Mail Senders Can Easily Type In The Wrong E-Mail Address.
* E-Mail Can Be Used To Introduce Viruses Into Computer Systems.

 How We Will Use E-Mail

1. We Will E-Mail You Instructions To Set-Up Your Patient Portal.
2. We Will Limit E-Mail Correspondence To Established Patients Who Are Adults 18 Years Or Older, Or The Legal Representatives Of Established Patients.
3. We Will Use E-Mail To Communicate With You Only About Non-Sensitive And Non-Urgent Issues
4. All E-Mails To Or From You Will Be Made A Part Of Your Medical Record. You Will Have The Same Right Of Access To Such E-Mails As You Do To The Remainder Of Your Medical File.
5. Your E-Mail Messages May Be Forwarded To Another Office Staff Member As Necessary For Appropriate Handling.
6. We Will Not Disclose Your E-Mails To Researchers Or Others Unless Allowed By State Or Federal Law. Please

Refer To Our Notice Of Privacy Practices For Information As To Permitted Uses Of Your Health Information And Your Rights Regarding Privacy Matters.

I May Want To Communicate With Dr. Japera N. Levine DPM, PLLC, And The Office Staff By E-Mail. I Understand The Risks Of Communicating By E-Mail, In Particular The Privacy Risks Explained In This Form. I Understand That Dr. Japera N. Levine DPM PLLC Cannot Guarantee The Security And Confidentiality Of E-Mail Communication. Dr. Japera Levine Will Not Be Responsible For Messages That Are Not Received Or Delivered Due To Technical Failure, Or For Disclosure Of Confidential Information Unless Caused By Intentional Misconduct.

I Understand That I May Also Communicate With Dr. Japera Levine DPM, PLLC By Telephone Or During A Scheduled Appointment, And That E-Mail Is Not A Substitute For Care That May Be Provided During An Office Visit. Appointments Should Be Made To Discuss Any New Issues Or Any Sensitive Medical Information.

I Understand That Either Dr. Japera N. Levine DPM PLLC Or I May Stop Using E-Mail As A Means Of Communication Upon My Written Request. My Revocation Of Consent Will Not Affect My Ability To Obtain Future Health Care Nor Will It Cause The Loss Of Any Benefits To Which I Am Otherwise Entitled.

I Have Read And Understand This Form. I Have Had The Opportunity To Ask Questions And My Questions Have Been Answered To My Satisfaction. I Understand And Agree With The Information Contained In This Form And Give My Consent For E-Mail Communications To And From Dr. Japera N. Levine DPM PLLC.

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Authorization to Treat Minor Patient in Absence of Parent/Guardian**

Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form is to authorize any person who is **NOT** the parent/guardian to be present with the patient for an office visit in the event the parent is not able to bring the patient in for their appointment.

By signing this document, you are giving the person listed below authorization to make medical decisions for your child in your absence.

To revoke authorization, a letter must written and new consent must be signed. The person authorized must present to office with a picture ID.

You may list more than one person, but any person not listed on this consent will be sent home without the patient being seen for their appointment.

**Dr. Japera Levine** is not responsible for any decisions made by the authorized personnel without the parent/guardian’s knowledge.

Phone calls will not be permitted during the patient’s visit in order for the parent/guardian to be contacted.

If you do not wish to authorize anyone other than the parent/legal guardian to bring the patient in for an appointment, please indicate that at the bottom of the page.

You can simply write, “Do not consent” in the blank space.

If you do not authorize anyone besides the parent/guardian to bring the patient in for his or her appointment, the parent/guardian must be present to each visit.

Any child under the age of 18 will **NOT** be seen without a parent/guardian/authorized person present.

Parent/Legal Guardian Name & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Person Name & DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Person Name & DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Person Name & DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS FORM PERTAINS TO ANYONE UNDER THE AGE OF 18 ONLY**

**Patient’s Financial Responsibility Policy**

* **Payment Is Due At The Time Of Service-Without Exception**. We Will Accept Visa,

MasterCard, Discover, Or Cash. We Do Not Accept Amex Or Check.

* Your Insurance Policy Is A Contract Between You And Your Insurance Company.

It is your responsibility to know/understand your insurance benefits.

As A Courtesy, We Will File Your Insurance Claim For You If You Assign The Benefits To The

Doctor. If Your Insurance Company Does Not Pay The Practice Within A Reasonable Period,

We Will Look To You For Payment.

* **Copayments**: By Law We Must Collect Your Carrier Designated Copay At The Time Of Service.
* **Referrals**: If Plan Requires A Referral From Your PCP It Is Your Responsibility To Obtain The Referral Or Assure That Your PCP’s Office Has Obtained The Referral Prior To Your Appointment.
* **Non-Plan Patients/Non Insured**: Payment Is Expected At Time Of Service.
* **Medicare**: We Will Submit To Medicare For The Entire Medicare Allowed Amount. The Patient Will Be Responsible For The Deductible And The 20% Co-Insurance, Which Can Be Billed Directly To Secondary Insurance If You Have One.
* We Have Made Prior Arrangements With Certain Insurers And Other Health Plans To Accept

An Assignment Of Benefits. We Will Bill Those Plans With Which We Have An Agreement And

Will Only Require You To Pay The Co‑Pay/Co‑Insurance/Deductible At The Time Of Service Or

Any Services That Are Deemed Not Medically Necessary Or Covered By Your Plan.

* All Health Plans Are Not The Same And Do Not Cover The Same Services. In The Event

Your Health Plan Determines A Service To Be "Not Covered," Or You Do Not Have

An Authorization, You Will Be Responsible For The Complete Charge. We Will Attempt To

Verify Benefits For Some Specialized Services Or Referrals; However, You Remain Responsible

For Charges To Any Service Rendered. Patients Are Encouraged To Contact Their Plans For Clarification Of Benefits Prior To Services Rendered.

* You Must Inform The Office Of All‑Insurance Changes And Authorization/Referral Requirements Prior To Your Arrival. In The Event The Office Is Not Informed, You Will Be Responsible For

Any Charges Denied.

* For Most Services Provided In The Hospital, We Will Bill Your Health Plan. Any Balance

Due Is Your Responsibility.

* Past Due Accounts Are Subject To Collection Proceedings. All Costs Incurred Including,

But Not Limited To, Collection Fees, Attorney Fees, And Court Fees Shall Be Your Responsibility

In Addition To The Balance Due To This Office. Your Past Due Balance Will Be Collected At

Your Next Office Visit Or Be Paid Within 30 Days Of The Statement Date;

Whichever Comes First. There Is A Service Fee Of $35.00 For All Returned Checks.

Your Insurance Company Does Not Cover This Fee.

* Treatments For Injuries/Accidents Related To “On-The-Job” Or Automobile Accidents

Involving Attorneys Are Required To Be Paid In Cash. We Will Not File Your Insurance For

These Visits.

* We Are Sorry To Inform You That **All Nail/Callus Trimming Is Not A Covered Service**

**By Your Insurance Plan** And Results In A $50 Charge Up Front. Any Medicaid Patients

Requiring Diabetic Foot Exams Will Have An Out Of Pocket Expense. In Addition, Medicaid

Will Not Cover Any Wound Debridement.

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(Signature) (Printed Name) (Date)