Steven J. Lieberson, D.P.M., P.C.
Fellow, American College of Foot and Ankle Surgeons
Diplomate, American Board of Foot and Ankle Surgery
Podiatrist - Foot Specialist

17510 W. Grand Parkway S. Suite 360
Sugar Land, TX 77479
Office (281) 242-3233 / Fax (713) 654-7095

ALL INFORMATION IS STRICTLY CONFIDENTIAL / ***PLEASE PRINT NEATLY!! ***

PATIENT NAME: _____ GENDER: M F

HOME ADDRESS: _____
Street Apt# City, State, Zip

DATE OF BIRTH: _____ SS#: _____-_____-_____

MARITAL STATUS: M S W D UNKNOWN PREFERRED LANGUAGE: _____

ETHNICITY _____ RACE _____

HOME PHONE #: _____ WORK PHONE #: _____ x _____

CELL PHONE #: _____ E-MAIL ADDRESS: _____

EMPLOYMENT STATUS: _____ EMPLOYER: _____

WHO REFERRED YOU TO OUR OFFICE? : _____

SPOUSE - OR - PARENT

NAME: _____ GENDER: M F

DATE OF BIRTH: _____ SS#: _____-_____-_____

IN CASE OF AN EMERGENCY: _____
NAME PHONE# RELATIONSHIP

INSURANCE INFORMATION

PLEASE CIRCLE ONE: HMO PPO POS MEDICARE (or HMO/PPO) MEDICAID (or HMO/PPO)
OTHER: _____

PATIENT INSURANCE: _____

INSURED NAME _____ INSURED D.O.B. _____

POLICY #: _____ GROUP#: _____

SECONDARY INSURANCE: _____

INSURED NAME _____ INSURED D.O.B. _____

POLICY #: _____ GROUP#: _____

PAGE 2 CONTINUE

MY FOOT PROBLEM IS _____ HOW LONG? _____

PRIOR OR SELF TREATMENT _____ HOW LONG? _____

NAME OF PREVIOUS DOCTOR: _____

Check any of the following you HAVE HAD or NOW HAVE:

____ DIABETES	____EPILEPSY (SEIZURE)	____ LOW BACK PAIN	____ LIVER PROBLEMS
____ CANCER	____ TUBERCULOSIS	____ STOMACH ULCERS	____ BLOOD PROBLEMS
____ GOUT	____ SHORT OF BREATH	____ FAINTING SPELLS	____ POOR CIRCULATION
____ KIDNEY PROBLEMS	____ PRONE TO INFECTION	____ PHLEBITIS	____ VARICOSE VEINS
____ HIGH BLOOD PRESSURE	____ HEART TROUBLE	____ LEG CRAMPS	____ HEPATITIS
____ ANEMIA	____ ARTHRITIS	____ UNEQUAL LEG LENGTH	____ HIV (AIDS)
____ ASTHMA	____ SICKLE CELL	____ STROKE	____ OTHER
____ GLAUCOMA	____ BLEEDING TENDENCY		_____

ALL PREVIOUS OPERATIONS OR HOSPITALIZATIONS? _____

_____

_____

DO YOU SMOKE? _____ HOW MUCH? _____ DO YOU DRINK ALCOHOL? _____ HOW MUCH? _____

DO YOU TAKE ANY ILLICIT / STREET DRUGS? _____

ANY KNOWN ALLERGIES TO MEDICINES? (PLEASE CIRCLE!!)

PENICILLIN SULFA ASPIRIN CODEINE LOCAL ANESTHESIA TAPE ANTIBIOTICS

OTHER _____ NONE KNOWN

(PLEASE CIRCLE!!) FAMILY HISTORY (Blood Relatives) DIABETES CANCER BLEEDER HIGH BLOOD PRESSURE HEART TROUBLE TB HEPATITIS HIV (AIDS) _____

PRIMARY CARE PHYSICIAN _____ PHONE #_____

DATE OF LAST EXAM: _____ IF FEMALE, COULD YOU BE PREGNANT? _____Weeks:_____

REVIEW OF SYSTEMS:

Do you have any of the following? (PLEASE CIRCLE!!)

FEVER	EYE PROBLEMS	PROBLEM SWALLOWING	ALLERGIES (SEASONAL)
NOSE/ SINUS PROB.	THYROID PROBLEM	GLAUCOMA	WEIGHT CHANGE (GAIN/LOSS)
SORE THROAT	HORMONE PROBLEM	BLOOD IN URINE	CHEST PAIN
FAST / SLOW PULSE	STOMACH PROBLEM	LYMPH GLAND PROB.	TROUBLE WITH URINE/KIDNEY
MUSCLE PAIN	BONE PAIN OR PROB.	SKIN PROBLEM	ULCERS OR SKIN CANCER
BALANCE PROBLEM	NERVE PROBLEMS	EAR PROBLEM	MENTAL OR EMOTIONAL PROBLEM
NERVOUS DISORDER	GLAND PROBLEM	TRANSFUSION	BREAST LUMPS
BLEEDING TENDENCY	WEAR GLASSES	SORES / MOUTH	NEUROLOGICAL/MUSCULAR PROB.
ANXIETY	MIGRAINE HEADACHES	OTHER: _____	

I HEREBY GIVE DR. LIEBERSON D.P.M. PERMISSION TO EXAMINE AND TREAT MY FEET:

SIGNATURE: _____ DATE: _____

PATIENT, PARENT OR GUARDIAN'S

PRINT PATIENT'S NAME: _____

Steven J. Lieberson, D.P.M., P.C.

Patient Profile

Pt. Name	Date of Birth	Sex Male Female

Allergies

1. 2. 3. 4. 5.

Pharmacy Name / Location	Pharmacy Number
Medication with mg	Problem
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	

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FINANCIAL RESPONSIBILITY AGREEMENT

I will be financially responsible for the medical expenses that I incur if my insurance eligibility cannot be verified at the time of my visit, and/or if it is determined by my insurance company that the services provided are not a covered benefit. I understand that when I am billed for these services I am expected to make payment in full or arrange with the business manager to make payments in a timely manner, if I do not the I understand that my account will be reviewed and could be placed with a collection agency. Court costs and reasonable collection fees could be added to my balance. I also understand that nonpayment could result in my account being reported to the credit bureau. **Any hospital, anesthesia, radiology, or associated lab fees are payable separately and not included with the fees associated with the services provided by the rendering physician or his staff. Please contact the facility to obtain their fee information.**

_____
Patient or responsible Party Signature

_____
Date

_____
Witness

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INITIALS

_____**Assignment of Benefits**
I hereby authorize payment directly to Dr. Lieberson of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

_____**Authorization to Release Information**
I authorize Dr. Lieberson to release any and all information contained in my complete medical and billing record to :

1) my insurance company or its representatives
2) other persons or entities financially responsible for my care or treatment
3) the Medicare or Medicaid programs and their fiscal intermediaries, if applicable or otherwise required or permitted by laws, regulation, and/or
4) Federal or state agencies, required or permitted by laws or regulation

_____**Financial Responsibility / Ancillary Services**
I understand I am financially responsible to Dr. Lieberson for all charges for the services to me. I hereby promise payment to Dr. Lieberson for all services I receive. During the course of your physician/patient relationship, the aforementioned physician may refer you to one or more acillary services including, but not limited to,Interventional Radiology services, Pharma Select Texas, The Hospital for Surgical Excellence of Oak Bend Medical Center and/or St. Joseph Medical Center.

In connection with any referral to one or more of the ancillary services, you are hereby advised that your physician may have an ownership interest in such ancillary service and therefore will receive, directly or indirectly, remuneration as a result of such referral

This information is being provided to you at the time of the aforementioned physician's first contact with you as a patient and will also be provided to you at the time of referral, if any, to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician with a different health care provider. You will not be treated differently by your physician or the physician's staff, if you choose to use a different health care provider.

Should your physician at any time refer you to any of the above referenced ancillary services and your prefer to use a different health care provider, you will be advised of alternative health care providers and your right to choose one of these alternative health care providers.

_____Copies
A photo stat copy of this authorization is as valid as the original. It will remain in effect until I submit a written request to revoke it.

My signature indicates I have read and understand all the preceding information.

Patient Name_____

Patient or Responsible Party Name_____

Signature_____Date_____

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Consent for Release of Information

I have read the NOTICE OF PRIVACY PRACTICES. I am aware that my "Protected Health Information" (PHI) will be disclosed to those physicians involved in my care, my insurance company(ies) and business associates of the practice, for the purposes of carrying out treatment, payment or health care operations. In addition, I have specified my preferences for routine uses and disclosures, as indicated below.

Name _____ DOB _____

Please check any/all of the following methods that would be appropriate for our office.

_____ Address _____

_____ Home # _____ _____ Work # _____

_____ Cell # _____ _____ Email Address: _____

Is it suitable to leave a message?
(CHECK ALL THAT APPLY)

_____ on answering machine _____ with adult household member

_____ exclusively with patient

Who is authorized to receive patient medical/billing information?
(CHECK ALL THAT APPLY)

_____ patient only _____spouse _____ family member (name) _____

_____ other (please specify) _____

I understand that further authorization(s) may be necessary, as required by law, should an additional disclosures of my PHI be requested.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Date

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Dr. Steven J. Lieberson, D.P.M., P.C. has provided you access to its Privacy Notice, which explains how your health information will be handled in various situations. Upon request a hard copy will be issued. By law, we are required to have you sign this form on your first date of service with us.

***** The Practice has provided me access to its Privacy Notice. I understand I may request a copy for my personal use.**

_____ _____
Patient's Signature Date

_____
Print Patient's Name

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OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

To assist us in establishing your financial account with us, the following must be done:

- COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DOCTOR.
- CO-PAY AND DEDUCTIBLE PAYMENTS ARE DUE AT THE TIME OF SERVICE.
- PAYMENT CAN BE IN THE FORM OF CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMEX.

MINORS ACCOMPANIED BY AN ADULT
The parents (or guardians) accompanying a minor are responsible for full payment at time of service.

REGARDING INSURANCE
If you have insurance, we will assist you in receiving maximum benefits. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

On major surgery or office visits, we may accept your insurance if we obtain approval from your insurance prior to the date of service. If your insurance company has not paid the FULL BALANCE within 60 days, you have 30 days to pay the balance.

PPO/HMO
Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan. Verification of your plan is required. Therefore, you must show your current card to our receptionist each visit.

MEDICARE/MEDICAID
The federal government requires that all Medicare/Medicaid claims be filed by your physician. Therefore, you must come to our office each visit to show your Medicare/Medicaid card. We regret the inconvenience, but in order for you to receive your Medicare/Medicaid benefits the federal government requires that all the rules are followed to their specifications.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Patient Signature _____ Date_____

ALLERGIES

Name of Med. -			
Location - Reaction			
Skin	**Local**	**Abdominal**	**Systemic / Anaphylactic**
Rash - Localized Rash - Generalized Itchiness Patchy swelling - skin Facial swelling Hives	Conjunctivitis Runny nose Cough	Pain / Cramping Bloating / Gas Vomiting Diarrhea Nausea	Shortness of Breath Wheezing Tongue Swelling Difficulty Speaking or Swelling Dizziness / Light Headedness Loss of Consciousness Chest Pain Irregular Heartbeat Tachycardia Bradycardia Respiratory Distress
Start Date		**Severity**	
		Very Mild Mild Moderate Severe	
Comment			

Patient's Name _____

D.O.B _____ Date _____