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 340
Sugar Land, TX 77479
Office (281) 242-3233 / Fax (713) 654-7095

Welcome to our office!

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

PATIENT INFORMATION:

PATIENT NAME: ________________________ D.O.B.: ____________ GENDER: ☐ M ☐ F

PREFERRED NAME: ________________________ MARITAL STATUS: ☐ Single ☐Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

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

HOME PHONE #: ____________________ CELL PHONE #: ____________________

E-MAIL: ________________________

EMPLOYMENT STATUS: ☐ Part-Time ☐ Full-Time ☐ N/A STUDENT STATUS: ☐ Part-Time ☐Full-Time ☐ N/A

PRIMARY LANGUAGE SPOKEN: ______________ ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Decline

RACE: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Other ☐ Decline

HOW DID YOU LEARN ABOUT OUR OFFICE? ________________________________

EMERGENCY CONTACT:

NAME: ______________ PHONE #: ______________ RELATIONSHIP: ______________

INSURANCE INFORMATION: ☐ **CASH PAY**

NAME OF INSURANCE: ________________________ TYPE OF PLAN: ☐ HMO ☐ PPO

GUARANTOR / INSURED NAME: ______________ GUARANTOR / INSURED D.O.B.: ______________

MEMBER ID / POLICY # ______________ GROUP#: ____________

SECONDARY INSURANCE: ☐ **N/A**

NAME OF INSURANCE: ________________________

GUARANTOR / INSURED NAME: ______________ GUARANTOR / INSURED D.O.B.: ______________

MEMBER ID / POLICY # ______________ GROUP#: ____________

PHARMACY INFORMATION:

PHARMACY NAME: ______________________________ PHARMACY PHONE #: ______________________________

ADDRESS:____
Street Apt# City, State, Zip

PRIMARY CARE PHYSICIAN:

NAME: ____ PHONE #: ____

ADDRESS:____
Street Apt# City, State, Zip

DATE LAST SEEN: ________________________________

ARE YOU OR DO YOU THINK YOU ARE PREGNANT?: ☐ N/A ☐ No ☐ Yes If yes, how many weeks? ________________

For patients 65 years or older: Do you have a living will or someone to make decisions on your behalf? ☐ N/A ☐ No ☐ Yes

HISTORY OF PRESENT ILLNESS:

REASON FOR TODAY'S VISIT: ____

____

____

____

DATE OF ONSET / INJURY: _________________________________

SYMPTOMS: ☐ Pain ☐ Swelling ☐ Infection ☐ Other: ____

LOCATION OF SYMPTOMS: ☐ Right ☐ Left ☐ Both

PREVIOUS TREATMENTS: ☐ Medication ☐ Stretching ☐ Change of Shoes ☐ Surgery ☐ Other __________________

HAVE YOU EXPERIENCED THIS PROBLEM BEFORE: ☐ No ☐ Yes If yes, when: _________________

CURRENT PAIN LEVEL: ☐ Mild ☐ Moderate ☐ Severe

HOW MANY HOURS PER DAY DO YOU SPEND ON YOUR FEET?: _________________

WHAT TYPE OF SHOES DO YOU WEAR DAILY?: ____

PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following?

Yes	DISEASE / CONDITION:	Yes	DISEASE / CONDITION:	Yes	DISEASE / CONDITION:
☐	Anemia	☐	Diabetes	☐	Eczema
☐	Sickle Cell Anemia	☐	GERD	☐	Psychiatric / Mental Disorder
☐	Angina	☐	Ulcers	☐	Stroke
☐	Heart Attack	☐	Colitis	☐	TIA
☐	Heart Disease / Condition	☐	Hepatitis / Liver	☐	Seizures
☐	Arthritis	☐	Gall Bladder	☐	Thyroid
☐	Osteoporosis	☐	High Blood Pressure	☐	Endocrine Problem
☐	Asthma	☐	High Cholesterol	☐	Tuberculosis
☐	COPD	☐	HIV / AIDS	☐	Autoimmune Disease
☐	Emphysema	☐	Kidney Failure	☐	Other: ____________________
☐	Bleeding / Clotting Disorder	☐	Kidney Stones	☐	Other: ____________________
☐	Cancer: Type: ________________	☐	Psoriasis	☐	Other: ____________________

PAST SURGICAL HISTORY: ☐ **DENIES PREVIOUS SURGICAL HISTORY AND/OR HOSPITALIZATION**

SURGICAL PROCEDURE	YEAR
☐ Angioplasty	________
☐ Angioplasty w/ Stent	________
☐ Appendectomy	________
☐ Arthroscopy Knee	________
☐ Back Surgery	________
☐ CABG (Heart Bypass)	________
☐ Carpal Tunnel Release	________
☐ Cataract Extraction	________
☐ Colon Surgery, Describe: ____________________	________
☐ Gastric Bypass	________
☐ Hernia Repair	________
☐ Hip Replacement (L / R)	________
☐ Knee Replacement (L / R)	________
☐ LASIK	________
☐ Liver Biopsy	________
☐ Pacemaker	________
☐ Small Bowel Resection	________
☐ Thyroidectomy	________

SURGICAL PROCEDURE	YEAR
☐ Tonsillectomy	________
☐ Fracture Repair	________
☐ Foot Surgery	________
☐ Other: ____________	________
☐ Other: ____________	________
Male Only	
☐ Prostate Biopsy	________
☐ TURP (Trans-urethral Resection of Prostate)	________
☐ Vasectomy	________
☐ Other: ____________	________
☐ Other: ____________	________

SURGICAL PROCEDURE	YEAR
Female Only	
☐ Augmentation Mammoplasty	________
☐ Bilateral Tubal Ligation	________
☐ Breast Biopsy	________
☐ Cesarean Section	________
☐ D and C	________
☐ Hysterectomy	________
☐ Mastectomy	________
☐ Myomectomy	________
☐ Reduction Mammoplasty	________
☐ Other: ____________	________
☐ Other: ____________	________
☐ Other: ____________	________

PATIENT NAME: ____

OTHER HOSPITALIZATIONS (NON-SURGICAL) :

REASON **DATE**

____

____

____

____

____

____

____

SOCIAL HISTORY:

Tobacco / nicotine / E-cig / Vape Use: ☐ Never ☐ Yes, how often: ____________ ☐ Former Smoker - Date quit: ___________

Alcohol Use: ☐ Never ☐ Social ☐ Occasional ☐ Moderate ☐ Heavy ☐ Recovering Alcoholic

Recreational Drug Use: ☐ Never ☐ Occasional ☐ Often ☐ Recovering Addict If yes, Drug of choice: _______________

Exercise: ☐ Moderate ☐ Never ☐ Often

FAMILY HISTORY: ☐ **ADOPTED** ☐ **UNKNOWN / NO SIGNIFICANT FAMILY HISTORY**

Does an immediate family relative **(Mother, Father, Sister, Brother ONLY)** been diagnosed with any of the following?

Please check applicable diseases / conditions

DISEASE / CONDITION:	Mother	Father	Sister	Brother
Diabetes				
Cancer				
Bleeding Disorder				
High Blood Pressure				
High Cholesterol				
Heart Trouble				
Heart Attack				
TB				
Hepatitis				
HIV/AIDS				
Autoimmune Disease				

DISEASE / CONDITION:	Mother	Father	Sister	Brother
Kidney				
Liver				
Thyroid				
Stroke / TIA				
Seizures				
Other: _________________				
Other: _________________				
Other: _________________				
Other: _________________				
Other: _________________				
Other: _________________				

PATIENT NAME: ____

MEDICATIONS:

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________

MEDICATION NAME	DOSE (mg, mcg, etc.)	REASON FOR MEDICATION

ALLERGIES: ☐ **NO KNOWN DRUG ALLERGIES**

NAME OF DRUG	REACTION (i.e. trouble breathing, rash, etc.)	SEVERITY
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

ALLERGIES: ☐ **NO KNOWN FOOD ALLERGIES**

NAME OF FOOD	REACTION (i.e. trouble breathing, rash, etc.)	SEVERITY
____________________	__________________________	☐ Mild ☐ Moderate ☐ Severe
____________________	__________________________	☐ Mild ☐ Moderate ☐ Severe
____________________	__________________________	☐ Mild ☐ Moderate ☐ Severe
____________________	__________________________	☐ Mild ☐ Moderate ☐ Severe
____________________	__________________________	☐ Mild ☐ Moderate ☐ Severe

REVIEW OF SYSTEMS:

Are you **currently** (today) experiencing any of the following signs or symptoms? If yes, please describe:

Yes	SYMPTOMS:	Describe all "Yes" responses
☐	**Eyes** (e.g. blurred vision, double vision, loss of vision)	__________________________
☐	**Ears, Nose, Throat** (e.g. sore throat, earache, ringing)	__________________________
☐	**Cardiovascular** (e.g. chest pain, palpitations, ankle swelling)	__________________________
☐	**Respiratory** (e.g. shortness of breath, bronchitis, asthma)	__________________________
☐	**Gastrointestinal** (e.g. ulcer, gastritis, GI bleed, jaundice)	__________________________
☐	**Genitourinary** (e.g. burning, bleeding, difficulty urinating)	__________________________
☐	**Musculoskeletal** (e.g. joint, muscle, back pain)	__________________________
☐	**Skin** (e.g. acne, psoriasis, cellulitis)	__________________________
☐	**Neurological** (e.g. numbness, tingling, weakness)	__________________________
☐	**Mental Health** (e.g. depression, anxiety, memory loss)	__________________________
☐	**Endocrine** (e.g. weight loss / gain, excess thirst / urination)	__________________________
☐	**Hematologic** (e.g. bleeding / clotting disorder, anemia)	__________________________

To the best of my knowledge, the information provided on all pages is accurate and complete. I understand it is my responsibility to inform my doctor if I, or my child, ever has a change in health.

Signature of Patient ***or*** Parent/Guardian (if signing for minor child) :______________________________________

Printed Name: ____________________________________ Date: _________________

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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, then 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

INITIALS

________Assignment of Benefits
I hereby authorize payment directly to Steven J. Lieberson, D.P.M., P.C. of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

________Authorization to Release Information
I authorize Steven J. Lieberson, D.P.M., P.C. 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

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: ______________________________ D.O.B.: ______________

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

☐ ADDRESS ____
Street Apt# City, State, Zip

☐ HOME # ______________ ☐ WORK # ______________________

☐ CELL # ______________ ☐ EMAIL: ______________________

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

☐ voicemail ☐ 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 DO NOT wish to grant authorization of any of my information to any family members / personal representatives

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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ACKNOWLEDGMENT 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 / Guardian's Signature (if signing for minor child) Date

____

Printed 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's Signature / Guardian's Signature (if signing for minor child) Date