Robin Lie, DPM
Sports and General Podiatry
11326 Mountain View Ave., Suite A
Loma Linda, CA 92354

PATIENT INFORMATION

Title **First Name** **MI** **Last Name**

Address **Apt#**

City **State** **Zip Code** **County**

Home Ph. ( ) **Work Ph. ( )** **Social Security #**

Cell Ph. ( ) **Email**

Date of Birth Age Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed

Spouse's Name Home Ph. ( ) Work Ph. ( )

Patient's Employer **Patient's Occupation**

Employer Address **City** **State** **Zip Code**

Emergency Contact not living with you Home Ph. ( ) Work Ph. ( )

Emergency Contact Address City State Zip Code

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

First Name MI Last Name

Address City State Zip Code

Work Ph. ( ) Date of Birth Social Security #

Employer Address City State Zip Code

INSURANCE INFORMATION

Primary Insurance Company Phone ( ) Effective Date

Address City State Zip Code

Policy Holder's Name DOB SSN

ID # Group #

Secondary Insurance Company Phone ( ) Effective Date

Address City State Zip Code

Policy Holder's Name DOB SSN

ID # Group #

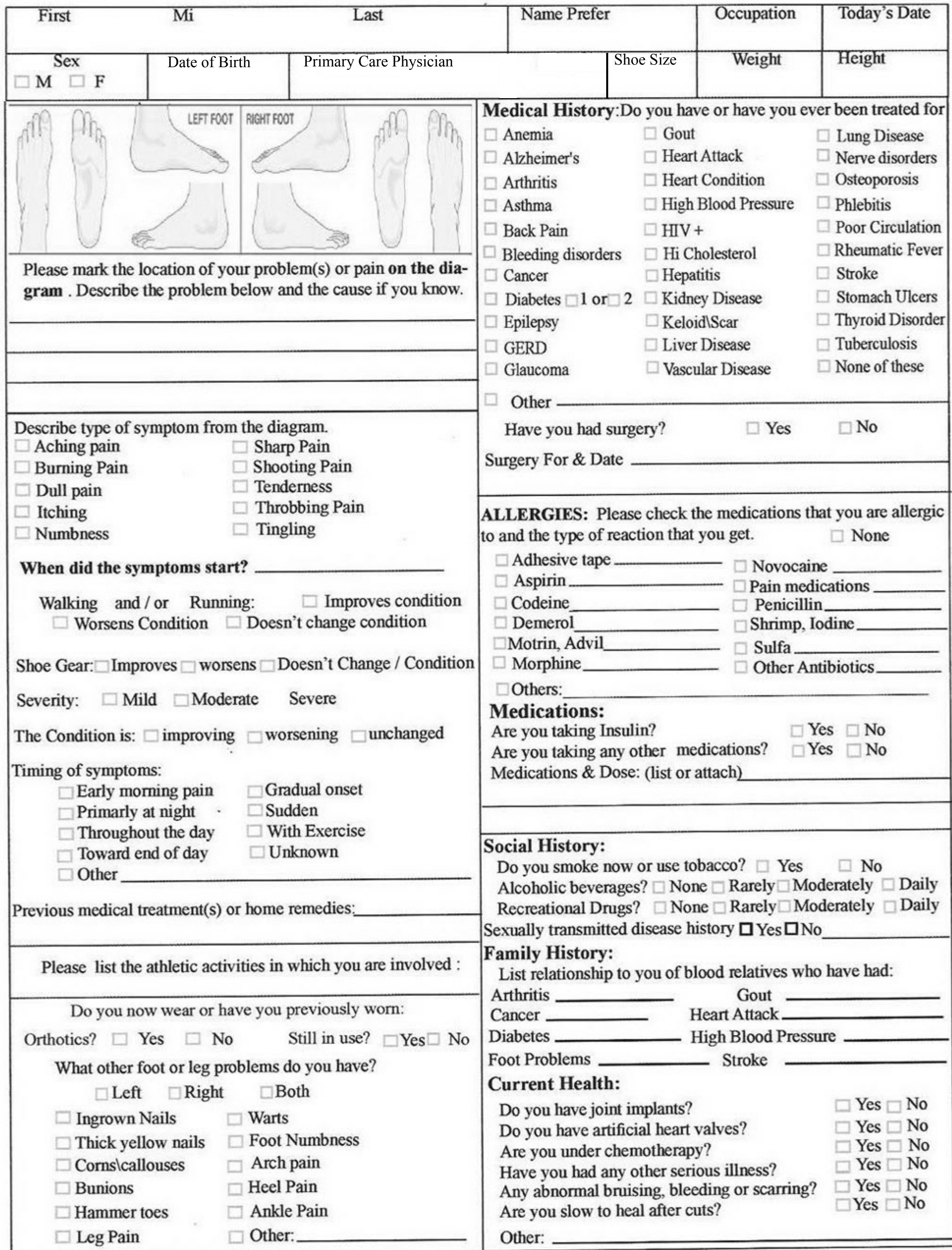
How did you learn about our office? ☐ I saw your sign. ☐ I was referred by Dr. ________________________
☐ A friend or another patient referred me. ☐ Yellow Pages ☐ Website ☐ Other:______________________

It is the policy of our office that all fees are due at the time services are rendered whether by check, cash or credit card unless prior arrangements have been made. We welcome frank discussion of services and fees at the time of treatment in order to avoid any misunderstandings.

We are happy to file your insurance for you, however, regardless of insurance coverage; you are responsible for payment of your account within the credit policy of this office. If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient.

I authorize the release of any medical/surgical information necessary to process this claim and authorize payment of medical/surgical/medical equipment benefits to be made directly to Robin Lie, DPM. After all insurance payments have been paid I fully understand that I am responsible for the remaining balance of my account.

Signature of Patient or Responsible Party: ____ **Date:** ________________________



First	Mi	Last	Name Prefer	Occupation	Today's Date

Sex ☐ M ☐ F	Date of Birth	Primary Care Physician	Shoe Size	Weight	Height

Please mark the location of your problem(s) or pain **on the diagram** . Describe the problem below and the cause if you know.

Describe type of symptom from the diagram.

☐ Aching pain ☐ Sharp Pain
☐ Burning Pain ☐ Shooting Pain
☐ Dull pain ☐ Tenderness
☐ Itching ☐ Throbbing Pain
☐ Numbness ☐ Tingling

When did the symptoms start? ____________

Walking and / or Running: ☐ Improves condition ☐ Worsens Condition ☐ Doesn't change condition

Shoe Gear: ☐ Improves ☐ worsens ☐ Doesn't Change / Condition

Severity: ☐ Mild ☐ Moderate Severe

The Condition is: ☐ improving ☐ worsening ☐ unchanged

Timing of symptoms:

☐ Early morning pain ☐ Gradual onset
☐ Primarily at night ☐ Sudden
☐ Throughout the day ☐ With Exercise
☐ Toward end of day ☐ Unknown
☐ Other ____________

Previous medical treatment(s) or home remedies: ____________

Please list the athletic activities in which you are involved :

Do you now wear or have you previously worn:

Orthotics? ☐ Yes ☐ No Still in use? ☐ Yes ☐ No

What other foot or leg problems do you have?

☐ Left ☐ Right ☐ Both

☐ Ingrown Nails ☐ Warts
☐ Thick yellow nails ☐ Foot Numbness
☐ Corns\callouses ☐ Arch pain
☐ Bunions ☐ Heel Pain
☐ Hammer toes ☐ Ankle Pain
☐ Leg Pain ☐ Other: ____________

Medical History: Do you have or have you ever been treated for

☐ Anemia ☐ Gout ☐ Lung Disease
☐ Alzheimer's ☐ Heart Attack ☐ Nerve disorders
☐ Arthritis ☐ Heart Condition ☐ Osteoporosis
☐ Asthma ☐ High Blood Pressure ☐ Phlebitis
☐ Back Pain ☐ HIV + ☐ Poor Circulation
☐ Bleeding disorders ☐ Hi Cholesterol ☐ Rheumatic Fever
☐ Cancer ☐ Hepatitis ☐ Stroke
☐ Diabetes ☐ 1 or ☐ 2 ☐ Kidney Disease ☐ Stomach Ulcers
☐ Epilepsy ☐ Keloid\Scar ☐ Thyroid Disorder
☐ GERD ☐ Liver Disease ☐ Tuberculosis
☐ Glaucoma ☐ Vascular Disease ☐ None of these
☐ Other ____________

Have you had surgery? ☐ Yes ☐ No

Surgery For & Date ____________

ALLERGIES: Please check the medications that you are allergic to and the type of reaction that you get. ☐ None

☐ Adhesive tape ________ ☐ Novocaine ________
☐ Aspirin ________ ☐ Pain medications ________
☐ Codeine ________ ☐ Penicillin ________
☐ Demerol ________ ☐ Shrimp, Iodine ________
☐ Motrin, Advil ________ ☐ Sulfa ________
☐ Morphine ________ ☐ Other Antibiotics ________
☐ Others: ____________

Medications:

Are you taking Insulin? ☐ Yes ☐ No
Are you taking any other medications? ☐ Yes ☐ No
Medications & Dose: (list or attach) ____________

Social History:

Do you smoke now or use tobacco? ☐ Yes ☐ No
Alcoholic beverages? ☐ None ☐ Rarely ☐ Moderately ☐ Daily
Recreational Drugs? ☐ None ☐ Rarely ☐ Moderately ☐ Daily
Sexually transmitted disease history ☐ Yes ☐ No ________

Family History:

List relationship to you of blood relatives who have had:

Arthritis ________ Gout ________
Cancer ________ Heart Attack ________
Diabetes ________ High Blood Pressure ________
Foot Problems ________ Stroke ________

Current Health:

Do you have joint implants? ☐ Yes ☐ No
Do you have artificial heart valves? ☐ Yes ☐ No
Are you under chemotherapy? ☐ Yes ☐ No
Have you had any other serious illness? ☐ Yes ☐ No
Any abnormal bruising, bleeding or scarring? ☐ Yes ☐ No
Are you slow to heal after cuts? ☐ Yes ☐ No
Other: ____________

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

____________ ____________
Date Signature

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice takes effect on December 2, 2010 and remains in effect until replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time as applicable law permits. Any changes made effect all health information we maintain, including health information created or received before the change went into effect. Any changes will be reflected in this notice and the revised notice will be made available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for a variety of reasons. Typical situations are described below.

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Communications: We may send appointment reminder postcards or leave voice mail messages reminding you of appointments or changes in appointments. We will use the phone numbers and address provided by you to send these communications. We may also have a sign-in sheet at the front desk of our office, where all patients sign in upon arrival.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any prior disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to help locate you and determine your general health condition; we may also use or disclose information to help identify and/or locate a family member, personal representative or other person responsible for your care. If you are available and competent, you will be contacted for permission before the information is disclosed. If you are incapacitated or in an emergency situation, we will determine the need for disclosure based on our professional judgment.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we have reason to believe that you are a possible victim of abuse, neglect, domestic violence or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information required for lawful intelligence, counterintelligence and other national security activities to authorized federal officials. We may disclose protected health information to correctional institution or law enforcement officials who have lawful custody of a patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at and receive copies of your health information, with limited exceptions. Requests must be submitted in writing; send a letter or complete a request form provided by the practice. We may charge you a reasonable fee for staff time and materials; charges will vary depending on the details of your request. You may be charged per page or per hour of staff time for copying records, and for postage for mailing records to you or another provider. Additional charges may be incurred for requests for health information summaries, or providing records in alternative formats. Every effort will be made to honor requests unless we cannot practically do so. Contact the office for a complete explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances when we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities. Records of this information are available from December 2, 2010 onward. Reports are limited to six years of activity. One report request per year is complimentary; if you request this report more than once in a 12 month period, we may charge you a reasonable fee.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. Additional restriction requests must be submitted in writing. We are not required to agree to these additional restrictions. If we do, we will agree to them in writing.

Alternative Communication: You have the right to request that we communicate with you by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation of how payments will be handled under the alternative circumstances.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice via our Web site or by electronic mail (e-mail), you are also entitled to request a notice in hard-copy format. Contact the office to receive a hard copy.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact the practice privacy officer (see below). If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or you are unhappy with our response to a request you made about your privacy rights, please submit your concerns in writing to the office. You may also submit a written complaint to the US Department of Health and Human Services; we will provide contact information upon request. We support your right to health information privacy and will not retaliate in any way if you choose to file a complaint with us or the US Department of Health and Human Services.

Privacy Officer: Robin Lie, DPM
Telephone: (909) 796-2705
Fax: (909) 799-1828
E-Mail: dr_lie@runfootdoc.com
Address: 11326 Mountain View Ave., Suite A
Loma Linda, CA 92354

Office for Civil Rights – California
Phone: (415) 437-8310

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Acknowledgment of Receipt of Notice of Privacy Practices
Note: You are not required to sign this form.

I acknowledge that I have read, or had the opportunity to read if I so chose, and understood this office's Notice of Privacy Practices.

____ ______________________
Signature Date

____
Patient Name (please print)

____
Parent or Authorized Representative (if applicable)

For office use only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment could not be obtained because (check all that apply):

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgment
____ An emergency situation prevented us from obtaining acknowledgment
____ Other (please specify below)

____
____

Office personnel signature: ____

Date: _____________