Andrew J. Lemoi, D.P.M. Inc.

WELCOME TO OUR OFFICE

The following information is necessary for our records and your foot health.

Patient Name_____ Date of Birth_____ Age_____

Street Address_____

City_____ Zip_____ Telephone_____

Name of Spouse/Parent (for minors)_____

Gender: M___ F____ Marital Status_____

Employer_____ Occupation_____ Business Telephone_____

Person to contact in emergency_____ Telephone_____

Name of family physician_____ Referred by_____

What is your present foot problem?_____

Have you been previously treated for this problem? ____Yes ____No

If yes, by whom?_____

Height_____ Weight_____ Shoe Size_____ Alcohol ___Yes ___No

Current medical problems:_____

Current herbal or dietary supplements:_____

What medications are you currently taking:_____

_____

Please list **Medication Allergies** and **Reactions**:_____

_____

Current Smoker_____ Former Smoker_____ Never Smoker_____

Number of Packs a Day_____ Number of Years Smoked_____ Date Quit_____

I have been treated for:	___Diabetes	___Heart Trouble	___High Blood Pressure
___Bleeding Tendencies	___Anemia	___Asthma	___Hepatitis/Liver Trouble
___Arthritis	___Gout	___Stomach Ulcers	___Thyroid Disease
___Epilepsy	___Nervousness	___Stroke	___Cancer
___Kidney/Bladder Trouble	___Glaucoma	___Circulatory Problems	___High Cholesterol
___Rheumatoid Arthritis			

Please use the reverse side to write more information if necessary.

Signature_____ Date_____

Warwick
215 Toll Gate Road
Suite 209
Warwick, RI 02886
TEL: (401) 886-1132
FAX: (401) 415-0994

South County
481 Kingstown Rd
Wakefield, RI 02879

ANDREW J. LEMOI. D.P.M., INC.

RELEASE OF INFORMATION
I, authorize my insurance company, organization, employer, hospital, physician, or pharmacist to release requested information with regard to attached claims and the expenses reported.

WAIVER OF LIABILITY
When dealing with Medicare or other insurance companies assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or other insurance companies as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. The patient may be notified of non-covered services by the physician.

I understand that I am responsible for meeting my deductible and forwarding my payments for services. Failure to do so will result in my owing the entire balance and any associated collection fees.

AUTHORIZATION OF PAYMENT FOR MEDICAL BENEFITS
Any and all benefits are hereby assigned to Dr. Andrew Lemoi. I also authorize the release of medical records. I understand I am liable for charges not covered by the insurance. If it is necessary to enforce collection of any amount due, the patient agrees to pay all collection costs and charges including all court costs and reasonable attorney fees.

I authorize payment of benefits, as determined by the insurance company, directly to:

Andrew J. Lemoi, DPM, Inc.
215 Toll Gate Rd Suite 209
Warwick, RI 02886
Federal Tax ID# 01-0575829

Signed:

Patient or Employee	Date
Parent or Guardian if patient u Under 18 years old	Relationship to Patient

Please feel free to contact the office if you have any billing questions. If you are unsure of your charges please bring your bill or explanation of medical benefits to your next visit. We will be happy to explain it to you at that time.

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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION

DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its terms.

Name of Patient_____

Date of Birth_____

Signature of Patient/Parent/Guardian _____

Date_____

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain areas of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____ **Relationship**_____

Print Name:_____ **Relationship**_____

Print Name:_____ **Relationship**_____

_____ _____

Name of Patient (Print) Signature Date

Witness: _____ Date: _____

ANDREW J. LEMOI, DPM

DUE TO THE RATE OF MISSED APPOINTMENTS WITHOUT NOTICE, THE FOLLOWING POLICIES HAVE COME INTO EFFECT REGARDING CANCELLATION OF APPOINTMENTS.

1. DR. LEMOI'S OFFICE MUST BE CONTACTED 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT IN ORDER FOR YOU TO AVOID BEING HELD RESPONSIBLE FOR A $50.00 FEE FOR A MISSED APPOINTMENT OR A $40.00 FEE FOR A MISSED ORTHOTIC APPOINTMENT.

2. IN THE EVENT THAT YOU MISS TWO OR MORE APPOINTMENTS WITHOUT PROPERLY CANCELING AND RESCHEDULING WE RESERVE THE RIGHT TO ASK YOU TO FIND ANOTHER PODIATRIST.

3. WE ENCOURAGE PATIENTS TO RESCHEDULE THEIR APPOINTMENT IN INCLEMENT WEATHER CONDITIONS. NO MISSED APPOINTMENT FEE WILL BE ASSESSED.

_____ _____

PATIENT DATE

******PLEASE LIST PHARMACY*******

_____

NAME OF PHARMACY

_____

STREET ADDRESS

_____

CITY, STATE