

# 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) \_\_\_\_\_

SS# \_\_\_\_\_ 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 Allergies and Reactions: \_\_\_\_\_

Current Smoker \_\_\_\_\_ Former Smoker \_\_\_\_\_ Never Smoker \_\_\_\_\_

Number of Packs a Day \_\_\_\_\_ Date Quit \_\_\_\_\_

I have been treated for:

___ Diabetes	___ Heart Trouble	___ High Blood Pressure
___ Bleeding Tendencies	___ Anemia	___ Hepatitis/Liver Trouble
___ Arthritis	___ Gout	___ Stomach Ulcers
___ Epilepsy	___ Nervousness	___ Stroke
___ Kidney/Bladder Trouble	___ Glaucoma	___ Circulatory Problems
___ Rheumatoid Arthritis		___ High Cholesterol

*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

Cranston  
65 Sockanosset Cross Rd  
3<sup>rd</sup> Floor  
Cranston, RI 02921

East Greenwich  
1050 Main Street  
Suite 21  
East Greenwich, RI 02818

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.  
1050 Main Street, Suite 21  
East Greenwich, RI 02818  
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.

---

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

Cranston  
65 Sockanosset Cross Rd  
3<sup>rd</sup> Floor  
Cranston, RI 02921

East Greenwich  
1050 Main Street  
Suite 21  
East Greenwich, RI 02818

South County  
481 Kingstown Rd  
Wakefield, RI 02879

Andrew J. Lemoj, D.P.M., INC  
1050 Main Street, Unit 21  
East Greenwich, RI 02818  
P: 401-886-1132 F:401-415-0994

**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 \$20.00 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.

\_\_\_\_\_  
PATIENT

\_\_\_\_\_  
DATE

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

1050 Main Street, Suite 21

East Greenwich, RI 02818

P-401-886-1132

F- 401-415-0994

The information being collected below is a requirement requested by the Government and Insurance Companies.

**Patient Name**\_\_\_\_\_

**DATE OF BIRTH**\_\_\_\_\_

**Date**\_\_\_\_\_

## 1. Please Circle Languages Spoken:

English    Spanish    French    Portuguese    Italian    Russian

Chinese    Arabic    Japanese

## 2. Please Circle Race:

American Indian    Alaskan Native    Asian    Black/African American

Native Hawaiian    Other Pacific Islander    White

## 3. Please Circle Ethnicity:

Hispanic or Latino    Not Hispanic or Latino

## 4. Please List Pharmacy:

Name\_\_\_\_\_ Street\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_