Eric J. Lullove D.P.M., P.A.
Walk as if you are kissing the earth with your feet

# INTAKE FORM

## PATIENT INFORMATION

Last Name ____________ First Name ____________ MI ________ Sex ❐ M ❐ F

Date of Birth ____________ Age ________ Social Security # ____________

Address ____________ City ____________ Zip ________

Who can we thank for referring you/ how did you find us? ____________

Family Physician ____________ City ____________ Date of Last Visit ________

Pharmacy ____________ City ____________

Height ____________ Weight ____________ Shoe Size ____________

## PHONE NUMBERS

Home Phone ____________ Cell Phone ____________

Email ____________

In case of emergency, please contact:

Name ____________ Phone ____________

## EMPLOYMENT

Name of Employer ____________ City ____________

At your job do you: ❐ sit mostly ❐ stand mostly ❐ sit and stand

Are you required to wear a specific type of shoe/ boot? ____________

## REVIEW OF SYSTEMS Please check all that apply

| | |
|---|---|
| Nerve: | ❐ Foot Burning ❐ Foot Numbness ❐ Seizure ❐ Loss of Balance |
| Skin: | ❐ Rash ❐ Skin Sores ❐ Itching ❐ Dry Skin ❐ Toenail Changes |
| Orthopedic: | ❐ Joint Pain ❐ Muscle Pain ❐ Leg Cramps ❐ Weakness ❐ Knee Pain ❐ Back Pain |

## REASON FOR VISIT

Reason for today's visit ______________________ How Long? ____________

Severity of Pain or condition ❐ Mild ❐ Moderate ❐ Severe ❐ Severe at times

Type of pain (if painful) ❐ Sharp ❐ Dull ❐ Stabbing ❐ Aching ❐ Burning ❐ Other ________

This problem is ❐ Improving ❐ Worsening ❐ Unchanged

What makes it worse ❐ Activity ❐ Exercise ❐ Work ❐ Laying in Bed ❐ Other ________

What makes it better ❐ Rest ❐ Ice ❐ Heat ❐ Elevation ❐ Other ____________

What treatments have you tried, if any? ______________________________

## MEDICAL HISTORY Please check the ones that apply

❐ AIDS / HIV
❐ Diabetes (Insulin)
❐ Diabetes (No Insulin)
❐ Arthritis
❐ High Blood Pressure
❐ Stroke (CVA)
❐ Heart Trouble
❐ Kidney Disease
❐ Lung Disease (COPD)
❐ Hepatitis (A, B, C)
❐ Stomach Problems
❐ Anxiety / Depression
❐ Gout
❐ Fibromyalgia
❐ Blood Clots
❐ Artificial Joints
❐ Cancer: ____________

## FINANCIAL POLICY

*I give permission to Eric J Lullove, DPM, his associates or assistants to examine/treat me during the care of my condition. I understand that I am financially responsible for all charges, whether or not paid by insurance. The only limitation to my financial liability for charges not paid by insurance occurs in the event of contractual limitations to the charged fees that have been agreed upon by Eric J Lullove DPM PA and the insurance company. I authorize use of this signature for all insurance claims (including Medicare/Medicaid if applicable).*

*Signature* ______________________________ *Date* ________________

## PFSH

Past Surgeries ______________________________________________

Do you smoke tobacco? ❐ Yes ❐ No If yes, how many packs per day? __________

Do you drink alcohol? ❐ No ❐ Occasional ❐ Moderate ❐ Heavy

Circle all that apply. Family History of: Diabetes, Gout, Flat Feet, Ingrown Toenails, Bunions

## MEDICATIONS

________________ Dosage ________ ________________ Dosage ________
________________ Dosage ________ ________________ Dosage ________
________________ Dosage ________ ________________ Dosage ________

Allergies ______________________________________________

Greenworx Printing 903-872-5922

Name: ____________________________________________ DOB: ______________________

Please Circle ALL Allergies:

CODEINE PENICILLIN SULFA TAPE LATEX CORTISONE IODINE SEASONAL

OTHER ALLERGIES: ____________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

- Do we have permission to look at your previous medication from other doctors and or pharmacies? _____Yes _____ No

______________________________________________ Signature

________________________ Date

**Please give your insurance card and drivers license to the receptionist to be copied.**

# Insurance Information

**Primary Insurance:** ______________________________

**Policy # / Subscriber ID #:** ______________________________

**Relationship: ( ) Self ( ) Spouse ( ) Other Relation** ____________

**Name of Policy Holder:** ______________________________

**Policy Holder Date of Birth:** ____________________

**Policy Holder Social Security #:** ______________________________

**Secondary Insurance:** ______________________________

**Member #/Subscriber ID #:** ______________________________

**Relationship: ( ) Self ( ) Spouse ( ) Other Relation** ____________

**Name of Policy Holder:** ______________________________

**Policy Holder Date of Birth:** ____________________

**Policy Holder Social Security #:** ______________________________

**I acknowledge that the above is true to the best of my knowledge. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) as I so chose, and understand the notice.**

______________________________ ______________________________

Printed Name Date

______________________________ ______________________________

Signature Parent or Authorized Representative (if applicable)

**INSURANCE PATIENTS ONLY** – **(Please initial one & Sign Below)**

**_________ I understand that even though I am paying my copay or towards my deductible today that my insurance is being billed. I understand that I still may receive a bill and any remaining balances will be my full responsibility.**

**(Even if I have a secondary insurance.)**

**_________ I understand that my insurance is Out-of-Network – and even though I am paying my copay or towards my deductible today that my insurance is being billed out of network and my coinsurance could be higher. I understand that I still may receive a bill and any remaining balances will be my full responsibility.**

**_________ I understand that even though I have insurance – I have decided to opt out and pay as a self-pay cash patient. I understand that my insurance WILL NOT be billed and fees for services rendered must be paid today.**

_______________________________________ _________________________

**Signature** **Date**

---

**NO INSURANCE – CASH PATIENTS** – **(Please initial If NO Insurance & Sign Below)**

**_________ I understand that I do not have any insurance and as a cash patient all fees must be paid today for services rendered.**

_______________________________________ _________________________

**Signature** **Date**

## Medical Financial Consent Form

You agree, in order for us to service our account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors and its debt Collection agents may contact me/us as described above.

______________________________ ____________________

Borrower/Customer Signature Date

FINANCIAL AGREEMENT

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is furnished.
    - You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
    - For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is your responsibility to notify our front desk staff of any insurance or address changes.
3. You will be responsible for any charges that occur if we are not notified.

PATIENT AUTHORIZATION

I hereby authorize Dr. Lullove to administer such medication or procedures as are necessary on the basis of findings in my case. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency or its intermediary any information needed for this or a related insurance claim. I request that payment of authorized benefits be made to **Eric J Lullove DPM PA**, I agree to pay any charges incurred by me to **Eric J Lullove DPM PA**. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ I authorize **Eric J Lullove, DPM PA** to submit insurance claims using my signature on file below.

_____ I authorize the release of any medical information necessary in order to process this assignment on this claim.

_____ I authorize payment of medical benefits to be paid directly to **Eric J Lullove DPM PA** for services described on the claim form.

**ALL CO-PAYS AND/OR CO-INSURANCES ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.**

I authorize Dr. Lullove to release any medical or billing information necessary for treatment, payment, or healthcare operations to the following healthcare professions, family, and/or friends:

| | |
|---|---|
| ______________________________ | ______________ |
| Name | Relationship |
| ______________________________ | ______________ |
| Name | Relationship |
| ______________________________ | ______________ |
| Name | Relationship |

| | |
|---|---|
| ______________________________________ | ______________ |
| Patient Signature (or authorized representative) | Date |

## Consent for Use and Disclosure of Personal Information
## Audio/Video/Photo/Authorization and Release

I understand that photographs, recordings, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Eric J Lullove DPM PA will retain the ownership rights to these photographs, recordings videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in [insert company] policy.

I, the undersigned, authorize Eric J Lullove DPM PA and West Boca Center for Wound Healing and/or parties designated by Eric J Lullove DPM PA to take photograph(s), videotape, and digital recording(s) of me and consent to the use of any of these in any and all media for educational and promotional purposes including, but not limited to, advertising; audiovisual; medical health editorials; exhibition; media relations; scientific posters and publications, online medical health sites and web.

I understand that the information collected is required by Eric J Lullove DPM PA for its lawfully authorized health-care related activities.

I understand and agree that I will not receive any payment for my time or expenses or any royalty for the publication of the photograph(s,) videotape, digital recording(s) and I hereby release [Insert Company] and/or any parties designated by Eric J Lullove DPM PA from the payment of any such claims.

I understand that photographs and/or videos may be downloaded, used, reproduced, and/or altered without consent by unknown users of Eric J Lullove DPM PA website, and that this is beyond Eric J Lullove DPM PA control. I hereby release Eric J Lullove DPM PA of any and all liability arising from such downloading, use, reproduction, or alteration.

I acknowledge and declare that I have read and fully understand the contents of this Consent and Release, and that all questions pertaining to this consent have been answered to my satisfaction. I declare that I am at least eighteen (18) years of age and have authority and capacity to bind myself and have voluntarily executed this Consent.

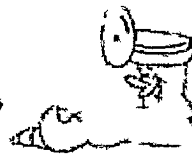
____________________________________________________

Signature Date

________________________________

Printed Name

# Eric J. Lullove D.P.M.



## CONTRACT FOR CONTROLLED SUBSTANCES

Controlled substance medication (narcotics-opioids, tranquilizers, barbiturates, i.e. any drug which induces sleep or stupor) can be very useful, but have high potential for misuse or abuse and are, therefore, closely controlled by government agencies. Used properly, some of them can be very effective pain medicine. If used excessively, however, they can cause adverse effects, such as impaired judgment, vomiting, constipation, lethargy, organ damage, or even death To ensure these medications are used properly, I agree to the following conditions

1. I am RESPONSIBLE for my controlled substance medication. IF THE PRESCRIPTION OR MEDICATION IS LOST, STOLEN OR MISPLACED, OR IF I USE IT UP SOONER THAN PRESCRIBED, I UNDERSTAND THAT IT WILL NOT BE REPLACED.
2. I will not request or accept narcotic medications from any other physician or individual while I am receiving such mediations from Eric J. Lullove, DPM (except if I am in the hospital) Besides being illegal to do so (Florida Statutes 893.0356), it may endanger my health
3. I understand that there will be a 24 to 48 hour turnaround time for non-narcotic medication refills; therefore, I will not wait until my medication is gone to request more medication. Controlled substances may be obtained only during a scheduled office visit. Refills will not be made at night, on holidays, or on weekends
4. I understand that if I violate ANY of the above conditions my controlled substance medication may be discontinued immediately. I am aware of "narcotic effects", including physiological effects of tolerance (need for more medication to achieve the same pain relief) and dependence (withdrawal may occur if I stop my medications abruptly) and the effects of addiction (psychological dependence), which is less common in patients with true pain. I also understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment, such as an automobile. I must use special care while involved in activities requiring clear though and concentration.

________________________ ________________________

Signature of Patient/Guardian Date signed

________________________ ________________________

Witness Signature Date Signed

2900 N. Military Trail Suite 244
Boca Raton, Fl. 33431
Ph: 561-989-9780 Fax: 561-989-9781
www.drlullove.com