Convulsions	□ M	□ P	Bleeding Tendency	□ M	□ P	Gout or other Arthritis	□ M	□ P	Hereditary Defects	□ M	□ P

Consent to Treatment

I hereby request and consent to treatment for **myself** or my **child**, here at the office of Eric J. Lullove, D.P.M., P.A.

Signature: _____ **Date:** _____

Authorization for Release of Medical Information

I authorize the release of any and all information acquired in the course of my examination and treatment of the purpose of securing payment of benefits for insurance company. A photocopy of this agreement is to be considered as valid as the original. This agreement shall not have an expiration date unless specified by the undersigned.

Signature: _____ **Date:** _____

Assignment of Benefits

I hereby assign all surgical and/or medical benefits for services rendered; to be paid directly to Eric J. Lullove, DPM PA will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Signature: _____ **Date:** _____

Financial Policy

- Please be prepared to pay your co-payment at every visit. Your co-payment amount is usually indicated on your insurance I.D. card.
- Please be prepared to pay your deductible (if not met) and any co-insurance amount at the time of your visit.
- Please bring your current insurance I.D. card to every appointment. If you arrive for your appointment and we are unable to verify your insurance coverage or authorization, you may reschedule your appointment to a later date, or you may elect to keep your appointment that day, but will be required to pay for the visit. If you keep your appointment, we will make a reasonable attempt to bill your insurance and request a refund directly to you.
- If your insurance requires authorization from your primary care physician, please make sure that you have one that is valid for your visit and that it covers any necessary tests needed.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. We highly recommend that you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.
- We will do all we can to assist your with your health insurance claims, however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you.
- A returned check charge of $50 will be charged to my account for each returned check.
- I acknowledge there will be a charge of $50.00 for missed appointment or cancellation without 24 hours noticed.

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Signature: _____ **Date:** _____

Notice of Privacy Practice

Eric J. Lullove DPM PA is committed to protecting the privacy of your medical and personal information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. Eric J. Lullove DPM PA protects your personal and health information in electronic, written and oral forms when used throughout our organization. We may modify or change our privacy practices from time to time, particularly as new laws and regulations become effective. Any changes will be effective for all the personal and health information we maintain, even information in existence before the change. If we materially modify our privacy practices, we will provide you with a new notice advising you of the changes. So that we may best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

I have read and understand the above information.

Signature: _____ **Date:** _____

7301 W. Palmetto Park Rd. Ste 201-C
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www.drlullove.com

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

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