RYAN FOOT AND ANKLE CLINIC, P.C.
LAWRENCE BROWN, D.P.M., D.A.B.P.S.

BOARD CERTIFIED, AMERICAN BOARD OF PODIATRIC SURGERY
BOARD CERTIFIED, AMERICAN BOARD OF PODIATRIC ORTHOPEDICS AND PRIMARY PODIATRIC MEDICINE
FELLOW, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS
FELLOW, AMERICAN COLLEGE OF FOOT AND ANKLE ORTHOPEDICS MEDICINE

25511 VAN DYKE, SUITE 100
CENTER LINE, MI 48015
TELEPHONE: (586) 758-5770
FACSIMILE: (586) 758-6134

WE ARE PLEASED TO HAVE YOU WITH US

We wish to welcome you to our office. Please answer these questions to help us become better acquainted. If you need any help, please don't hesitate to ask.

NAME_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ ZIP_____

HOME#_____ CELL#_____ WORK#_____

SOCIAL SECURITY#_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?_____

EMERGENCY CONTACT NAME AND NUMBER_____

I hereby give permission to Dr Lawrence Brown to administer treatment and to perform such minor operative procedures as deemed necessary in the diagnosis and/or treatment of my foot, leg or ankle condition.

I request that payment of authorized insurance benefits be made on my behalf to:
Ryan Foot and Ankle Clinic, P.C./Dr Lawrence Brown for any services furnished me by Dr Lawrence Brown. I authorize this clinic to release any information pertinent to my case to my insurance company (companies).

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company. I understand that it is my responsibility to know my insurance plan and all applicable limitations/restrictions and/or co-pays and deducible for which I may be charged.

A photocopy of this assignment shall be considered as effective and valid as the original.

PATIENT'S SIGNATURE_____ DATE_____

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INSURANCE AUTHORIZATION AND WAIVER FORM

PATIENT NAME_____

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO:
RYAN FOOT AND ANKLE CLINIC, P.C./ DR LAWRENCE BROWN FOR ANY SERVICES FURNISHED ME BY DR BROWN/CLINIC/SUPPLIER. I AUTHORIZE ANY HOLDER OF HOSPITAL AND/OR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR MY PRIVATE INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAYMENTS AND/OR DEDUCTIBLES. I WILL ALSO BE RESPONSIBLE FOR ANY SERVICES THAT ARE NOT COVERED BENEFITS BY MY INSURANCE CARRIER. IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE COVERAGE.

I GIVE PERMISSION TO RYAN FOOT AND ANKLE CLINIC, P.C. AND STAFF TO PERFORM THE FOLLOWING ACTS:

TO TRANSMIT MY INSURANCE CLAIMS ELECTRONICALLY, TO CALL INSURANCE COMPANIES REGARDING BENEFITS AND CLAIM STATUS, TO SEND OFFICE REMINDERS, AND TO SEND ALL LABS AND INFORMATION THROUGH THE LAB DELIVERY SYSTEM, TO CALL ME BY NAME IN THE OFFICE AND WAITING ROOM, AND TO CALL ME ON THE TELEPHONE AND LEAVE MESSAGES.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

PATIENT'S SIGNATURE_____DATE_____

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HIPAA PRIVACY AUTHORIZATION FORM

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS ESTABLISHED A "PRIVACY RULE" TO HELP INSURE THAT PERSONAL HEALTH CARE INFORMATION IS PROTECTED FOR PRIVACY. THE PRIVACY RULE WAS ALSO CREATED IN ORDER TO PROVIDE A STANDARD FOR CERTAIN HEALTH CARE PROVIDERS TO OBTAIN THEIR PATIENTS' CONSENT FOR USES AND DISCLOSURES OF HEALTH INFORMATION ABOUT THE PATIENT TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

AS OUR PATIENT, WE WANT YOU TO KNOW THAT WE RESPECT THE PRIVACY OF YOUR PERSONAL MEDICAL RECORDS AND WILL DO ALL WE CAN TO SECURE AND PROTECT THAT PRIVACY. WE STRIVE TO ALWAYS TAKE REASONABLE PRECAUTIONS TO PROTECT YOUR PRIVACY. WHEN IT IS APPROPRIATE AND NECESSARY, WE PROVIDE THE MINIMUM NECESSARY INFORMATION TO ONLY THOSE WE FEEL ARE IN NEED OF YOUR HEALTH CARE INFORMATION AND INFORMATION ABOUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS IN ORDER TO PROVIDE HEALTH CARE THAT IS IN YOUR BEST INTEREST.

YOU MAY REFUSE TO CONSENT TO THE USE OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION, BUT THIS MUST BE IN WRITING. UNDER THIS LAW, WE HAVE THE RIGHT TO REFUSE TO TREAT YOU SHOULD YOU CHOOSE TO REFUSE TO DISCLOSE YOUR PERSONAL HEALTH INFORMATION (PHI). IF YOU CHOOSE TO GIVE CONSENT IN THIS DOCUMENT, AT SOME FUTURE TIME YOU MAY REQUEST TO REFUSE ALL OR PART OF YOUR PHI. YOU MANY NOT REVOKE ACTIONS THAT HAVE ALREADY BEEN TAKEN WHICH RELIED ON THIS OR A PREVIOUSLY SIGNED CONSENT.

YOU HAVE THE RIGHT TO REVIEW OUR PRIVACY NOTICE, TO REQUEST RESTRICTIONS AND REVOKE CONSENT IN WRITING AFTER YOU HAVE REVIEWED OUR PRIVACY NOTICE.

PRINT NAME_____SIGNATURE_____

DATE_____

RYAN FOOT AND ANKLE CLINIC, PC

PATIENT NAME_____ DATE_____

PATIENT DEMOGRAPHIC INFORMATION

HEIGHT_____ MARITAL STATUS_____ SHOE SIZE_____

WEIGHT_____

WHAT IS THE PRIMARY LANGUAGE YOU SPEAK? _____

WHAT RACE ARE YOU? (CIRCLE ONE)

WHITE ASIAN BLACK/AFRICAN AMERICAN

AMERICAN INDIAN/ALASKA NATIVE NATIVE HAWAIIAN/PACIFIC ISLANDER

OTHER_____ UNKNOWN/DECLINED

EMAIL ADDRESS_____

WHAT IS YOUR PREFERRED METHOD OF CONTACT (CIRCLE ONE)

HOME PHONE CELL PHONE

PATIENT MEDICAL/FAMILY/SOCIAL HISTORY

CURRENT ALLERGIES_____

CURRENT MEDICATIONS IF NO MEDICATIONS PLEASE CHECK NO____

_____

_____

_____

FAMILY PHYSICIAN_____ NUMBER_____

DATE YOU LAST SAW THIS DOCTOR_____

NAME OF PRIMARY PHARMACY_____PHONE NUMBER_____

ANY PAST SURGERIES _____

_____

ANY PAST FOOT/ANKLE PROBLEMS

YES WHAT?_____

NO

ANY PAST FOOT/ANKLE SURGERIES

YES WHAT?_____

NO

DO YOU HAVE DIABETES

YES INSULIN_____PILLS_____DIET CONTROLLED_____

NO

DO YOU HAVE ANY ARTIFICIAL JOINTS?

KNEE HIPS OTHER _____

HAVE YOU FALLEN IN THE LAST YEAR? YES____ NO_____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO **YOU:**

ARTHRITIS	KIDNEY TROUBLE	LUNGS
CANCER	ASTHMA	ULCER
ANEMIA	HIGH BLOOD PRESSURE	GOUT
TUBERCULOSIS	RHEUMATIC FEVER	LIVER DISORDERS
STROKE	HEART TROUBLE	MULTIPLE SCLEROSIS
EPILEPSY	LUPUS	HEPATITIS
HIV/AIDS	FLAT FEET	DIABETES
THYROID DISEASE	NEUROLOGICAL DISORDER	SKIN DISORDER
GLAUCOMA	BUNIONS	HAMMERTOES
NEUROPATHY	PLANTAR FASCIITIS	HIGH CHOLESTEROL

FAMILY MEDICAL HISTORY

IS YOUR FATHER LIVING? YES NO

CAUSE OF DEATH (CIRCLE ONE)

NATURAL CANCER DIABETES HEART STROKE OTHER_____

IS YOUR MOTHER LIVING? YES NO

CAUSE OF DEATH (CIRCLE ONE)

NATURAL CANCER DIABETES HEART STROKE OTHER_____

IS THERE A **FAMILY** HISTORY OF:

HEART DISEASE BLEEDING DISORDER NEUROLOGICAL DISORDER

STROKE DIABETES HAMMERTOES/BUNION

FLAT FEET CIRCULATION

SOCIAL HISTORY

DO YOU SMOKE?

YES HOW MUCH?_____ HOW OFTEN?_____

NO EVER SMOKED?_____ DATE QUIT?_____

ALCOHOL QUANTITY IS:

NONE 1-2 PER WEEK 1-2 PER DAY 2 OR MORE PER DAY

EMPLOYER_____

TYPE OF JOB:

SITS AT JOB STANDS AT JOB

STANDS AND WALKS AT JOB RETIRED/UNEMPLOYED

SITS AND STANDS AT JOBS