DeFeo And Lilly
Podiatric Medicine And Surgery

BRAD H. LILLY, DPM
DIPLOMATE, AMERICAN BOARD OF FOOT AND ANKLE SURGERY
MEMBER, AMERICAN PODIATRIC MEDICAL ASSOCIATION

TREXLER PARK MEDICAL ARTS BLDG.
3131 COLLEGE HEIGHTS BLVD.
SUITE 1500
ALLENTOWN, PA. 18104
FAX (610) 820-7006
TELEPHONE (610) 821-0444

WELCOME TO OUR OFFICE

Our knowledgeable and caring staff make every effort to make your experience at our office pleasant and positive. In order to accomplish this, we ask that you complete the following:

* Please print ALL forms and complete them to the best of your ability.

* Please list all medications, dosage (milligrams), and how often each medication is taken each day on the information form. (You can also bring a list with you if that is more convenient.)

* Please bring the completed forms, your list of medications (if applicable), your insurance card(s), photo identification (ex: driver's license), and referral form (if your insurance requires one) to your appointment. **Please note that even if you have a Medicare Advantage plan, we still require a copy of your red, white, and blue Medicare card. If you do not bring the Medicare card with you, we will have to reschedule your appointment.**

* Please arrive at the office 10-15 minutes prior to your scheduled appointment time so that all your information can be entered into our system in order to avoid a delay to your scheduled time.

* If you must cancel or reschedule an appointment, please provide 24 hours notice.

HEALTH INSURANCES

Although our staff are very knowledgeable, there are a wide variety of insurance policies now available and they are constantly changing. We try our best to assist you, but insurance policies are a contract between you and your insurance company. Please note that Dr. Lilly and his staff are not responsible for your insurance coverage, nor verifying that we are in your insurance network. If you have any doubts about your coverage, please contact your insurance company.

DEFEO AND LILLY, PC
PATIENT INFORMATION SHEET

NAME:_____BIRTHDATE:_____/_____/_____AGE_____

SOCIAL SECURITY #:_____-_____-_____ (REQUIRED FOR COLLECTIONS AND/OR INSURANCE)

PHONE #:_____-_____-_____CELL #_____-_____-_____ E-MAIL: _____

MARRIED_____ SINGLE_____ OTHER_____ STUDENT_____ SEX: MALE_____ FEMALE_____

ADDRESS:_____CITY/STATE:_____ZIP:_____

OCCUPATION::_____EMPLOYER_____

EMPLOYER ADDRESS:_____

SPOUSE OR PARENTS NAME:_____REFERRED BY_____

EMERGENCY CONTACT: _____PHONE:_____

FAMILY PHYSICIAN_____FAMILY PHYSICIAN PHONE #_____

WHAT IS YOUR CHIEF COMPLAINT?_____

HAVE YOU PREVIOUSLY BEEN TO A PODIATRIST FOR TREATMENT?_____

HEIGHT _____ WEIGHT _____ SHOE SIZE _____

PRIMARY INSURANCE COMPANY NAME:_____

ID NO:_____**GROUP NO:**_____

SUBSCRIBER (IF OTHER THAN PATIENT): SPOUSE_____ PARENT_____ OTHER_____
LAST NAME:_____ FIRST NAME/MI_____
STREET:_____CITY/STATE:_____ZIP:_____
PHONE:_____-_____-_____ SEX: M_____F_____ BIRTHDATE: _____/_____/_____SS#_____
EMPLOYER:_____ADDRESS_____

SECONDARY INSURANCE COMPANY NAME:_____

ID NO:_____**GROUP NO:**_____

SUBSCRIBER (IF OTHER THAN PATIENT): SPOUSE_____ PARENT_____ OTHER_____
LAST NAME:_____ FIRST NAME/MI_____
STREET:_____CITY/STATE:_____ZIP:_____
PHONE:_____-_____-_____ SEX: M_____F_____ BIRTHDATE: _____/_____/_____ SS#_____
EMPLOYER:_____ADDRESS_____

A CHARGE WILL BE MADE FOR COMPLETION OF DISABILITY FORMS AND OTHER REPORTS. I HEREBY AUTHORIZE YOU TO RELEASE MEDICAL RECORDS TO MY INSURANCE COMPANY. I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO DEFEO AND LILLY, PC. I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING AND MAINTAINING ANY REFERRAL REQUIRED BY MY INSURANCE COMPANY AND PAYMENT OF ANY CO-PAY, COINSURANCE, DEDUCTIBLE, OR NON-COVERED SERVICES.

PATIENT AND INSURED_____**DATE**_____

PATIENT ACCOUNT#_____

11/25

DR. BRAD LILLY
PATIENT INFORMATION

NAME: _____ DOB: _____

PHARMACY; _____ Phone: _____

FAMILY DOCTOR: _____ Phone: _____

Past Medical History *Check all that apply*

Last Physician visit: ___/___/_____

- ☐ Alzheimer
- ☐ Anemia
- ☐ Arthritis
- ☐ - Lupus
- ☐ - Rheumatoid
- ☐ Blood Transfusion
- ☐ Cancer
  - Type ☐
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Thyroid Condition
- ☐ Stroke
  - Year ☐
- ☐ Heart Attack
  - Year ☐
- ☐ Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis
  - Type ☐
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ - Emphysema
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ - Dialysis
- ☐ Keloid
- ☐ - Do You Scar
- ☐ Gout
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Psychiatric Disorders
- ☐ Depression
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Skin Disorders
- ☐ Psoriasis
- ☐ Hearing Disorder
- ☐ Osteoporosis
- ☐ Stomach Ulcers
- ☐ - Reflux
- ☐ Poor Circulation
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Swelling Legs
- ☐ Back Problems
- ☐ Burning Feet
- ☐ - Neuropathy
- ☐ Foot Ulcer
- ☐ Foot Infection
- ☐ - Amputation
- ☐ Blood Thiners
- ☐ - Coumadin
- ☐ - Plavix
- ☐ - Other ☐
- ☐ Diabetes
  - ☐ - Insulin Controlled
  - ☐ - Oral Meds Controlled
  - ☐ - Diet Controlled
- ☐ Pregnant

Other:

MEDICATIONS: I BROUGHT MY MEDICATION LIST (AS REQUESTED) YES NO
(If not, please enter all medications below:)

ALLERGIES: (If no allergies, please write none)

SURGERIES: (If no surgeries, please write none)

NAME:_____ DOB: _____

FAMILY HISTORY

FATHER NAME: _____ AGE: _____

IF DECEASED, AGE AT DEATH _____ CAUSE OF DEATH: _____

MOTHER NAME: _____ AGE: _____

IF DECEASED, AGE AT DEATH _____ CAUSE OF DEATH: _____

SOCIAL HISTORY

DO YOU SMOKE? Y N AMT PER DAY?_____ QUIT_____

DRINK ALCOHOL? Y N BEER_____ WINE_____ LIQUOR_____

EXERCISE? Y N FREQUENCY_____

PERCENTAGE OF DAY YOU ARE ON YOUR FEET _____%

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FEET.

SIGNATURE:_____ DATE:_____

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PODIATRIC MEDICINE AND SURGERY

WILLIAM T. DEFEO, DPM
BRAD H. LILLY, DPM

MEMBER FINANCIAL LIABILITY ACKNOWLEDGMENT FORM

The undersigned member of any insurance company hereby agrees to be financially liable for and to pay to the provider the amount of charges for certain health care services. Before contemplating any elective procedure, scanning for orthotics, or x-rays, it is important for you to understand your insurance coverage. Please check to see if your insurance requires any of the following: Second Surgical Opinion, Precertification, and/or Pre-existing Clause.

I am aware that it is my responsibility to check my own insurance coverage for its guidelines. Due to numerous healthcare programs, I also understand that it is my obligation to insure participation of healthcare providers with my insurance plan. **I also understand that it is my responsibility to obtain a referral, to know the expiration date of the referral, and when to obtain a new referral**. Brad Lilly, DPM has no knowledge of other physicians and/or facilities' enrollments and is, therefore, not responsible for any fees charged outside of the practice. After considering the above, I understand that should my insurance carrier deny coverage due to the above, I automatically become responsible for any balance due.

In the event the member who will receive these services is a minor, the undersigned parent/guardian of that minor agrees to be financially liable for the services described above.

By using a check for payment, you agree to the following terms: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount of the check. Any returned check will be subject to a $25.00 fee.

Please note that if your account remains unpaid for a period of sixty (60) days, your account will be placed with Hamilton Law Group, PC for collection. You will be responsible for interest of l.5% per month (l8% per year), and for collection attorney fees of 35% on the unpaid balance and interest.

I have read this form and understand its contents.

This waiver remains in effect for all visits and charges, including my first visit and all future visits.

Patient's Signature_____
Witness:_____
Date: _____

1/23

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME_____

BIRTHDATE _____ SOCIAL SECURITY #_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

__ I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

PATIENT:

X_____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature

OFFICE USE ONLY:

__ Accepted _____ _____ _____

__ Denied | Signature | Title | Date