LA Medical

Primary Care

Dr. Ravi Pandey	Internal Medicine
Dr. Michael Sinclair	Family Medicine
Dr. Laurence Ehrlich	Internal Medicine
Dr. Anna Abel	Internal Medicine
Dr. AylenMorales	Internal Medicine
Dr. Andrea Forray	Family Medicine

Karina Solis-Ruelas, FNP-C
Sheena Urdaz, PA-C Alison Welch, FNP-APRN
Deisy Franco, PA-C Christie Pierre, FNP-APRN

Podiatric Medicine & Surgery

Dr. Lori Lane Dr. Christine Schuler
Dr. Daniel Heck
Dr. Dina Hansen
Dr. Khoa Pham
Dr. Derek Pawich
Dr. Liz Connolly
Dr. Naveed Chippa

Locations

Boynton Beach Jupiter
West Palm Beach
Loxahatchee
Palm Beach Gardens
Wellington
Palm Springs

Information

561-433-5577
info@lamedicalpb.com
myLAmed.com
Mon – Fri: 7:30am to 6:30pm

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Age:** _____ **Occupation:** _____

Sex: ☐ Male ☐ Female Weight: _____ Height: _____

Do you need a translator? ☐ Yes ☐ No Married? ☐ Yes ☐ No

Phone Number: _____

Email Address: _____

Mailing Address: _____

Ethnicity: ☐ White ☐ Hispanic ☐ African American ☐ Asian

☐ Not Listed _____

Emergency Contact and Relationship: _____

Emergency Contact Number: _____

Social Security Number: _____

Select The Type of Care Visit You are Here For

Primary Care ☐ Podiatric Medicine ☐

Previous Healthcare Provider + Their Phone Number (Facility or Physician):

_____

INSURANCE INFORMATION:

Primary Health Insurance: _____

Primary Policy Number: _____

Secondary Health Insurance: _____

Secondary Policy Number: _____

Are you currently employed? ☐ Yes ☐ No

Is today's encounter the result of a work injury? ☐ Yes ☐ No

Is today's visit the result of an auto-accident? ☐ Yes ☐ No

Employment Company Name: _____

Workers Comp. or Auto Accident Carrier: _____ Claim Number: _____ Date of Accident: _____

Name of Adjuster: _____ Their Phone Number: _____

How did you hear about us?

_____

PATIENT CONSENT FOR EXTENDED AUTHORIZATION AND TREATMENT & INFORMATION DISCLOSURE

I hereby voluntarily consent to receive medical care and treatment, including diagnostic procedures, surgical and medical treatment, as deemed necessary by all authorized healthcare providers at LA Medical Associates. This consent includes extended authorization for treatment beyond the initial plan, if deemed medically necessary by my provider, as long as it is in accordance with accepted medical standards.

I understand that my care is directed by LA Medical Associates and that other personnel render care and services to me according to the instructions by my provider(s) and LA Medical Associates.

I hereby acknowledge and understand that phone calls with LA Medical Associates are recorded for training purposes and LA Medical Associates may text or email me.

✘ _____ _____

Signature (parent if patient is a minor) *Date*

LA Medical Associates
(561) 433-5577
Fax: (561) 275-2696
lamedicalpb.com

Patient Financial Responsibility Agreement

Patient Name: _____ **Date of Birth:** _____

Insurance Provider: _____ **Policy Number:** _____

Understanding Your Financial Responsibility

We are committed to providing you with the best possible care and helping you navigate your insurance benefits. However, it is important to understand that:

1. **Your insurance policy is a contract between you and your insurance company.** While we will file claims on your behalf, it is ultimately your responsibility to ensure that your bill is paid.
2. **Coverage is not guaranteed.** Your insurance company may deny payment for services that are deemed not covered, out-of-network, or medically unnecessary.
3. **You are responsible for any balances not covered by insurance, including deductibles, co-pays, and co-insurance.**

Acknowledgment of Financial Responsibility

I understand that:

- I am responsible for all charges incurred for my treatment, regardless of insurance coverage.
- If my insurance does not pay for services, I will be billed directly and must pay the balance in full.
- I authorize the provider's office to file claims and receive payments directly from my insurance company.

Patient/Guardian Signature: _____ **Date:** _____

Office Representative Signature: _____ **Date:** _____

Medical Information Release Form

Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

☐ **I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:**

☐ **Spouse**_____

☐ **Children**_____

☐ **Other**_____

☐ **Information is not to be released to anyone.**

Signed: _____ **Date:**_____

Witness: _____ **Date:**_____

LA Medical Associates

Authorization to Request Medical Record Information

2326 S. Congress Ave., West Palm Beach, FL 33406 – Phone: 561-433-5577 Fax: 561-275-2696

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Requesting Records from (internal use only):

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Requesting the Release of the following Medical Records to LA Medical Associates:

I hereby authorize LA Medical Associates to receive Medical Records Information, including, but not limited to, Private Insurance Claim for applicable dates of service, all my medical records for all dates of service, specific diagnostic imaging/testing done, **protected information including psychiatric treatment notes, mental health information, HIV tests & related information, alcohol and/or substance abuse information.**

If applicable, please specify if there are any **protected health information or sensitive information that** should NOT be released to LA Medical Associates:

_____ **Initials:** _____

_____ _____

Patient Signature Date

_____ _____

Parent/Legally Recognized Representative Signature Date

*By my signature, I attest that I am the legally recognized representative of the above mentioned patient.
The information release pursuant to this authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to.

LA Medical

Medical History

Patient Full Name: _____

Reason for Visit: _____

Allergies

☐ No Allergies

ALLERGY	ALLERGIC REACTION

Medications

(If you need more room to list current medications, please ask a staff member to provide a blank sheet of paper)

MEDICATIONS (Please List All)	DOSAGE	TIMES PER DAY

Health Maintenance Screening Test History

CHOLESTEROL	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULT? Y N
COLONOSCOPY/SIGMOID	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULT? Y N
MAMMOGRAM	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULT? Y N
BONE DENSITY	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULT? Y N
CARDIAC STRESS TEST	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULT? Y N
RECTAL/PSA	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULT? Y N
EYE EXAMINATIONS	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULT? Y N
X-RAYS	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULT? Y N

LA Medical

Medical History

Hospitalization and Surgical History

DATE	HOSPITAL NAME OR SURGICAL PROCEDURE

Vaccination History

- ☐ **Received Typical Childhood Vaccinations**
- ☐ **Never Vaccinated**
- ☐ I have been vaccinated for the **Flu**
- ☐ I have **NOT** been vaccinated for the **Flu**
- ☐ I have been vaccinated for **COVID-19**
- ☐ I have **NOT** been vaccinated for **COVID-19**

Social History

TOBACCO USE	**Smoke Cigarettes? Y N (if you never smoked, please proceed to Alcohol/Drug Use)**
Current: Packs/day _____ Number of Years: _____	**Past:** Quit Date: _____ Packs/Day: _____ Number of Years: _____

Other Tobacco (circle): **Pipe** **Cigar** **Snuff** **Chew** **Vape**

ALCOHOL/DRUG USE	**Do you drink alcohol? Y N**	**Beer Wine Liquor**	**Number of Drinks/week:**

Do you use marijuana or recreational drugs? Y N **Have you ever used needles to inject drugs? Y N**

Have you ever taken someone else's drugs? Y N

Have you **recently** experienced any of the following? **--- Please circle all that apply**

Chest Pain	Fatigue	Difficulty Swallowing	Changes in Vision
Shortness of Breath	Changes in Urination	Constipation	Muscle Spasms
Cough	Headaches/Migraines	Feeling Anxious	Weakness
Weight Gain	Abdominal Pain	Vomiting	Difficulty Sleeping
Weight Loss	Diarrhea	Fevers, Chills, Sweats	Pain

LA Medical

Medical History

Personal Medical History ---------- (*Please indicate all that apply to the best of your ability)*

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type: _____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type: _____)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (Hypertension)			
High Cholesterol			
Renal (kidney) Disease			
Hypothyroidism/Thyroid Disease			
Migraine Headaches			
Stroke			
Arthritis			
Others:			
Others:			

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Ankle Fracture			
Broken Foot or Toes			
Cramps in Foot/Calf			
Tendinitis			
Foot Numbness			
Gait (walking problems)			
Ulcers on Legs or Feet			
Neuroma			
Poor Circulation in Lower Limb			
Swollen Ankles/Feet			
Varicose Veins			
Pain in Feet			
Nail Conditions			
Other:			
Other:			

LA Medical

Medical History

Family Medical History

☐ *No Significant Family History Is Known*

CHECK ALL THAT APPLY ✓	ALCOHL/DRUG ABUSE	ASTHMA	CANCER	EMPHYSEMA (COPD)	DEPRESSION/ANXIETY	BIPOLAR/SUICIDAL	DIABETES	EARLY DEATH	HEART DISEASE	HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	KIDNEY DISEASE	STROKE	THYROID DISEASE	MIGRAINES	OTHER: _____	OTHER: _____	OTHER: _____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Grandmother																		
Grandfather																		
Other																		

Other Providers/Specialists

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Nephrologist		
Pain Specialist/Pain Doctor		
Orthopedist		
Other:		
Other:		

Pharmacy Information

Name of your preferred Pharmacy: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Patient Privacy Act (HIPPA), requires that our office obtains authorization to leave messages at your home with family members or on voice mail, email, etc. **I hereby give my consent for LA Medical Associates, doctors and staff to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) as follows:**

1. LA Medical Associates, doctors and staff's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by writing to LA Medical Associates at 2326 South Congress Avenue, Suite 1A, West Palm Beach, FL 33406. My protected health information means health information including, but not limited to my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or health clearing house, this protected health information relates to my past, present and future physical and mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

2. **PHONE CALLS:** LA Medical Associates, doctors and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

3. **MAIL:** LA Medical Associates, doctors and staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

4. **E-MAIL**: LA Medical Associates, doctors and staff may E-mail any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

5. I have the right to request that LA Medical Associates, doctors and staff restrict how they use or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

6. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LA Medical Associates, doctors and staff may decline to provide treatment for me. LA Medical Associates and doctors reserves the right to change its privacy practices that are disclosed

✘_____ _____

Signature (parent, if patient is a minor) ***Date***

_____ _____

Print Patients Name ***If applicable, Print Name of Legal Guardian***