Iliya Beylin, DPM, FACFAS, Foot and Ankle Surgeon

2929 N. University Drive, Ste 106. Coral Springs, FL 33065 (754) 702-2677

7800 W. Oakland Park Blvd, Ste 302B. Sunrise, FL 33351 (954) 325-9871

At Foot and Ankle Associates of South Florida, LLC it is our priority to improve quality of life through treatment of foot and ankle conditions. We are committed to a relationship built on care, compassion, and trust.

Dr. Beylin and staff would like to welcome you to this office. Please assist us in answering the following questions:

PATIENT INFORMATION

Date_____

First Name_____ MI ___ Last Name_____ Male Female

Address_____

City_____ State_____ Zip _____ e-mail _____

DOB_____ SSN _____

Home Phone_____ Cell Phone _____ Work Phone_____

Driver's License # _____ Driver's License State _____

Employer/ School _____

Business Address _____

If patient is a minor, please provide parents' information:

Mother's Name _____ Father's Name _____

Employer _____Employer _____

Name of a contact person in case of an emergency, other than a parent or spouse:

Name _____ Relationship _____

Address _____City_____ State_____

Phone Number _____

Primary Care Doctor:_____ Phone number:_____

How did you hear about us? Who can we thank for the referral? _____

PRIMARY INSURANCE

Name of Company _____ Phone _____

Address _____ City ____ State_____ Zip_____

ID# _____Group # _____

Insured Full Name_____ Insured SSN _____

Insured DOB _____

Relationship to Insured (self, spouse, child, other)_____

SECONDARY INSURANCE

Name Of Company _____ Phone _____

Address _____ City_____State____Zip_____

ID# _____Group # _____

Insured Full Name_____ Insured SSN _____

Insured DOB _____

Relationship to Insured (self, spouse, child, other)_____

Authorization For treatment/ Financial Agreement/ Release of Information:

I, the undersigned, knowing the patient, minor and/or self certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor and staff to administer and perform diagnostic and therapeutic procedures, including injections, as may be deemed necessary in the diagnosis and/or treatment of lower extremity. I understand that no guarantee has been made as to the result of the procedure/ treatment. I authorize release of medical information to my doctor, health agency, insurance company, government agency or worker's compensation. I request payment that payment to insurance benefits made on my behalf directly to the doctor. I assume full financial responsibility for all debts in any treatment. I understand that any unpaid balances will be assessed 1.5% per month. Any patient sent to collections will be assessed 25% surcharge of the balance. It is my responsibility to obtain authorization from Primary Care Physician or insurance company (if required) prior to services rendered.

Patient's or Legal Guardian's Signature _____ Date_____

Patient History

Name_____ **Date**____/____/____

Age_____ **Height**_____ **Weight**_____

1. What is the main problem with your feet/ankle/legs?

_____

_____

2. How long have you had the symptoms? _____

3. Is this an injury? _____Yes. _____ No. If yes, when did it occur?_____

4. Check all of the following that apply:

Type of Pain: ____Burning ____Tingling ____Shooting ____Stabbing

____Sharp ____Dull Ache ____Numbness

When Painful: ____ When standing ____Walking ____After walking

____At rest ____During sports ____Worse with activity

____With shoes ____Without shoes ____AM ____PM

5. How painful is the condition (0 = no pain. 10 = worst pain)

0 1 2 3 4 5 6 7 8 9 10

6. Medical History (please check conditions you have or had in the past)

____Diabetes	____Hepatitis	____Stomach ulcers
____High Blood pressure	____Heart problems	____Gout
____High cholesterol	____Thyroid disorder	____Kidney disorder
____Anemia	____Bleeding problems	____Fibromyalgia
____Asthma	____Osteoporosis	____HIV

Other:_____

7. Medications

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

8. Allergy

____None ____Penicillin ____Aspirin ____Sulfa ____Latex

____Codeine ____Anesthetic ____Iodine ____Cortisone

Other:_____

9. Surgical History

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

10. Family History (Please check all conditions that run in your family)

____Diabetes	____Hepatitis	____Stomach ulcers
____High Blood pressure	____Heart problems	____Gout
____High cholesterol	____Thyroid disorder	____Kidney disorder
____Anemia	____Bleeding problems	____Fibromyalgia
____Asthma	____Osteoporosis	____HIV

Other:_____

11. Social History

____Smoking ____Alcohol ____Recreational Drug Use

NOTICE OF PRIVACY PRACTICES (HIPPA REGULATIONS)

I acknowledge that I read or had an opportunity to read "Notice of Privacy Practices" and understand the notice. It is required by governmental regulations that all medical facilities provide you with this notice.

Signature_____ ***Date***_____

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100 NW 82nd Ave, Suite 106, Plantation, FL 33324. (954) 325-9871

Dear Patient,

We ask you that you please read and sign this form as it concerns you, the patient.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy, therefore we ask you, the patient, to please check with your insurance company regarding your coverage. It is **YOUR** responsibility to know **YOUR** individual coverage and its limitations. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. **Please remember that your insurance policy is between you and your insurance company.**

If you need a referral from your insurance company or from your primary care physician or from another doctor to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available. We welcome you to call your physician and have your referral faxed to us.

If you have a copayment or out-of-pocket expenses, deductibles, etc., it must be paid at the time of service.

Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out-of-pocket expense.

Name_____ Date_____

Signature_____

Foot and Ankle Associates of South Florida, LLC

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

The Consent was signed by:_____

Patient or Representative

_____

Print Name

Relationship to Patient:_____

(if other than the patient)

Witness: _____

Practice Representative