SIGNATURE ON FILE
PLEASE CHECK ALL THAT APPLY

___ I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS

___ I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES

___ I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL

___ I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES

___ I AUTHORIZE PAYMENT DIRECT TO MY DOCTOR

___ I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

NAME: _____

SIGNATURE: _____ DATE: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

ADVANCED FOOT AND ANKLE SPECIALISTS
MARK G. LEITNER, DPM., FACFAS
BRANDI JOHNSON, DPM., FACFAS
GLORIED M. EBSWORTH, DPM
(813) 571-2977
206 Buckingham Place Ste. 101
Brandon, FL 33511

WELCOME TO OUR OFFICE
PERSONAL INFORMATION

DATE:		REFERRED BY:	
NAME:		AGE:	BIRTHDATE:
ADDRESS:			
CITY:	STATE:		ZIP:
PHONE:	CELL PHONE:		SSN:
GENDER:	PHARMACY:		

MEDICAL PHYSICIAN:	TELEPHONE:
ADDRESS:	
OCCUPATION:	
EMPLOYER:	
ADDRESS:	
TELEPHONE:	
PERSON TO CONTACT IN CASE OF EMERGENCY:	
RELATIONSHIP:	TELEPHONE:
EMPLOYER:	TELEPHONE:

INSURANCE INFORMATION

PRIMARY INSURANCE:		
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:	NAME OF INSURED:	
DOB OF POLICY HOLDER:	SSN # OF POLICY HOLDER:	
POLICY:	GROUP:	
SECONDARY INSURANCE:		
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:	NAME OF INSURED:	
DOB OF POLICY HOLDER:	SSN# OF POLICY HOLDER:	
POLICY:	GROUP:	

I HEREBY GIVE DR. MARK LEITNER AND DR. BRANDI JOHNSON PERMISSION TO DIANOSE AND ADMINISTER TREATMENT FOR MY FOOT/ANKLE CONDITIONS.

PATIENT SIGNATURE: _____ DATE: _____

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PATIENT HISTORY

FOOT AND ANKLE CONCERNS: _____

_____

HOW LONG HAS THIS BEEN PRESENT: _____
GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ UNKNOWN
LIST ALL MEDICATIONS:

_____

SHOE SIZE: _____

REVIEW OF SYMPTOMS:

SENSORY
- ☐ IMPAIRED VISION
- ☐ NECK PAIN/STIFFNESS
- ☐ DIFFICULTY HEARING
- ☐ DIFFICULTY SWALLOWING

LUNGS
- ☐ COUGH
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH
- ☐ SNORING AT NIGHT

GI
- ☐ NAUSEA
- ☐ DIARRHEA
- ☐ VOMITTING
- ☐ CHANGE IN STOOL

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ PAIN IN CALVES
- ☐ IRREGULAR HEARTBEAT
- ☐ COLD FEET
- ☐ SWELLING IN FEET
- ☐ CRAMPS IN FEET
- ☐ CIRCULATION PROBLEMS

NEUROMUSCULAR
- ☐ JOINT PAIN/STIFFNESS
- ☐ LIMB LENGTH DISCREPANCY
- ☐ NUMBNESS FEET/LEGS
- ☐ MUSCLE ACHES/CRAMPS
- ☐ POPPING JOINTS
- ☐ BURNING IN FEET/LEGS
- ☐ FRACTURES
- ☐ LOSS OF HEIGHT
- ☐ HIP/KNEE/LOW BACK PAIN
- ☐ ARTHRITIS

SKIN
- ☐ ALLERGIC REACTIONS
- ☐ DERMATITIS
- ☐ WARTS
- ☐ ULCERS
- ☐ PIMENTATION CHANGES
- ☐ IRREGULAR MOLES

PAST MEDICAL HISTORY

	YES	NO		YES	NO
DIABETES	☐	☐	EMPHYSEMA	☐	☐
HEART DISEASE	☐	☐	CANCER	☐	☐
STROKE	☐	☐	THYROID PROBLEMS	☐	☐
RHEUMATIC FEVER	☐	☐	GOUT	☐	☐
EPILEPSY	☐	☐	PROLONGED BLEEDING	☐	☐
HIGH BLOOD PR	☐	☐	ULCERS	☐	☐
KIDNEY PROBLEMS	☐	☐	NEUROLOGICAL COND.	☐	☐
LIVER PROBLEMS	☐	☐	PSYCHOLOGICAL	☐	☐
ASTHMA	☐	☐	CONDITIONS		

OTHER PAST MEDICAL PROBLEMS: _____
PREVIOUS OPERATIONS: _____

ALLERGIES

PLEASE LIST ALL ALLERGIES:

_____

FAMILY PAST MEDICAL HISTORY

LIST ANY ILLNESS FOR FAMILY MEMBERS
MOTHER: _____Alive/Deceased/Unknown
FATHER: _____Alive/Deceased/Unknown
SISTERS: _____Alive/Deceased/Unknown
BROTHERS: _____Alive/Deceased/Unknown
FOR FEMALE PATIENTS: ARE YOU PREGNANT? ☐ YES ☐ NO
DATE OF LAST MENSTUAL PERIOD: _____

YOUR SOCIAL HISTORY

DO YOU SMOKE? ☐ Y ☐ N
DO YOU DRINK ALCOHOL ☐ Y ☐ N
DO YOU DRINK COFFEE/TEA ☐ Y ☐ N
DO YOU USE RECREATIONAL DRUGS? ☐ Y ☐ N
MARRIED: ☐ Y ☐ N
JOB TYPE: _____

HIPAA CONSENT
Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

___ Home Telephone_____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Work Telephone _____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Cell Telephone _____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Written Communication
- ___ OK to mail to my home address
- ___ OK to mail to my work/office address
- ___ OK to fax to this number _____

___ I give authorization for CSCD to leave a message in my absence with _____, _____ (indicate relation to patient) for matters regarding:
- ___ my appointment reminders
- ___ my account such as billing and amount due
- ___ my treatment/test results

I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.

_____ Patient Name (Print)

_____ Birthdate

_____ Signature

_____ Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitue and adequate record

Note: Uses and disclosures for Treatment Records, Payment Information and Healthcare Operations may be permited without prior consent in an emergency.

Record of Disclosures of Protected Health Information

(The section below is to be completed by Office Staff only when disclosing records)

Date	Disclosed to Whom Address or Fax No	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T = Treatment Records; P = Payment Information; O = Healthcare Operations
(3) Enter how disclosure was made: F = Fax; P = Phone; E = Email; M = Mail; O = Other

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

√ I acknowledge that I was provided with a summary and explanation of the Notice of Privacy Practices.
√ I understand that I may request a copy of the actual Notice if I so choose.
√ I have read (or had the opportunity to read) the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

I give authorization to discuss my protected health information to the following:

Name	Relationship	Date of birth
Name	Relationship	Date of birth
Name	Relationship	Date of birth

Advanced Foot & Ankle Specialists
206 Buckingham Place Suite 101
Brandon, FL 33511
Phone: (813) 571-2977 Fax: (813) 654-9545

FINANCIAL POLICY

The doctors and staff at Advanced Foot & Ankle Specialists would like to welcome you to our practice. We strive to provide you with the excellent medical care and our goal is to make your visits as convenient as possible. Our experienced office staff will be happy to answer any question regarding your account.

By signing below, you confirm that you have read this policy and understand that:

* It is your responsibility to inform our office of any address or telephone number changes.
* Your account is to be kept current—accordingly, all selfpay or insurance co-payments, co-insurances and deductibles will be collected at the time of service unless payment arrangements have been approved in advance IN WRITING. Payable by cash, check, Visa or MasterCard.
* If you do not have your payment (s), your appointment may be rescheduled.
* You may be asked to schedule another appointment for issues other than the reason for your original appointment.
* If you are more than 30 minutes late for your appointment, your appointment may be rescheduled.
* If you cancel your appointment less than 24 hours before your appointment time or no show your appointment then you will be charged for your visit.
* A returned check will result in a $25 service charge and all future payments being required in the form of cash or credit card.
* You will only be sent a statement if your balance exceeds $5 and you will only receive a refund if your credit amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, if there is no pending insurance claims.
* There is a $25 charge for completion of paperwork (ex: FMLA, Work Comp, etc). we required 7-10 business days for completion. There will be a $50 charge for paperwork that needs to be completed in less than 7 days.
* There is a $5 charge for Xrays and $1 for the first page of your medical records then $.25 thereafter.
* Any unpaid balances older than 60 days may be subject to 1.5% interest per month.
* If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE

We will submit your claims, however we must emphasize that as medical providers, **our relationship is with you, <u>not</u> your insurance company.** Although we attempt to verify your podiatric medical benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

* It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
* If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.
* Not all services are a covered benefit with all insurance plans.

* Insurance companies may impose a waiting period before providing coverage and they may exclude coverage for what they determine to be "pre-existing conditions". They may also require that you obtain prior approval before treatment.
* When we are able to verify your coverage and benefits in advance for Medicare and our approved private insurance plans, we will accept assignment of your insurance benefits and will bill the carrier directly. It is your responsibility to pay us directly for the deductible, co-payments and non-covered serviced and fees. In these circumstances, payment of your portion will be estimated at the time of services and must be paid at the time. It is your responsibility for any remaining balance after your insurance pays their portion. If your insurance company does not completely or promptly pay, you are responsible for paying the remaining balance immediately upon receipt of bill.
* It is your responsibility for any non-covered charges not payable by your insurance company policy.
* It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance policy.
* We are contract providers for Medicare and many private insurance plans. In those cases, we have agreed to accept their determination of fees for covered services. These payments are due at the time of service. Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Name (please print)	**Patient Signature**	**Date**
_____	_____	_____
Responsible Party (please print) (if other than patient)	**Responsibly Party Signature**	**Date**

Advanced Foot & Ankle Specialists

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this Offices "Notice of Privacy Practices".

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify)

_____

_____

Dr. Mark G Leitner, DPM
Dr. Brandi M. Johnson, DPM
Dr. Gloried M. Ebsworth, DPM

206 Buckingham Place, Ste 101
Brandon, FL 33511
Phone: (813) 571-2977
Fax: (813) 654-9545

I, _____, authorize Advanced Foot & Ankle Specialists, Dr Leitner, Dr Johnson, and/or Dr Ebsworth to download my prescription history from RX Hub which includes most major pharmacies. This is a valuable tool used by the physicians in this practice to obtain all of your recently prescribed medications that were filled at the pharmacy. This helps to avoid drug interactions and possible unwanted mixtures of certain medications.

___ I want this added to my profile.

___ I do not want this added to my profile.

_____
Patients Signature

_____
Date