

**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., AACFAS

(813) 571-2977

206 Buckingham Place Ste. 101  
Brandon, FL 33511

15511 North Florida Avenue  
Tampa, FL 33613

**WELCOME TO OUR OFFICE  
PERSONAL INFORMATION**

DATE:		REFERRED BY:	
NAME:		AGE: Years	BIRTHDATE:
ADDRESS:			
CITY:	STATE: FL	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: \_\_\_\_\_

# ADVANCED FOOT AND ANKLE SPECIALISTS

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## PATIENT HISTORY

FOOT AND ANKLE CONCERNS:

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HOW LONG HAS THIS BEEN PRESENT:

GENERAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR  UNKNOWN

LIST ALL MEDICATIONS:

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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
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PR	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
LIVER PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
GOUT	<input type="checkbox"/>	<input type="checkbox"/>
PROLONGED BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>
ULCERS	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL COND.	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHOLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>
CONDITIONS	<input type="checkbox"/>	<input type="checkbox"/>

OTHER PAST MEDICAL PROBLEMS: \_\_\_\_\_

PREVIOUS OPERATIONS: \_\_\_\_\_

### ALLERGIES

PLEASE LIST ALL ALLERGIES:

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### 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: \_\_\_\_\_

**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.

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Patient Name (please print)

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Date

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Parent or Authorized Representative (if applicable)

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Signature

## 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 the individual's home.

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

- |   |  |
|---|--|
| <input type="checkbox"/> Home Telephone: _____<br><input type="checkbox"/> Ok to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication: _____<br><input type="checkbox"/> Ok to mail to my home address<br><input type="checkbox"/> Ok to mail to my work/office address |
| <input type="checkbox"/> Work Telephone: _____<br><input type="checkbox"/> Ok to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Other: _____  |

Patient Signature	Date
Print Name	Birthdate

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 constitute an adequate record.

*Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.*

### Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax #	(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

## 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, not 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 services 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)	Responsible Party Signature	Date

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