

Advanced Foot & Ankle Specialists, P.A.

PATIENT INFORMATION

Name _____ DOB _____ Age _____

Mailing Address _____

City/State _____ Zip _____

Northern Address _____

City/State _____ Zip _____

Phone # _____ Out of State# _____

Cell# _____ Work# _____

SSN # _____ Male _____ Female _____

Email Address: _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced

Employer _____ Phone _____

Emergency Contact _____ Phone _____

Primary Physician _____ Phone _____

How did you hear about us? _____

Race: (Please Circle) American Indian or Alaskan Native (AI), Asian (A), Black (B), Caucasian (C), Other (E), Pacific Islander (P), Declined (7)

Ethnicity: Hispanic _____ Non-Hispanic _____

Primary Language: _____

Primary Insurance Information

Insurance Co. Name _____

Subscriber Name _____ DOB _____

Relationship to Patient _____ SSN# _____

Secondary Insurance Information

Insurance Co. Name _____

Subscriber Name _____ DOB _____

Relationship to Patient _____ SSN# _____

Is there a 3rd Insurance Carrier? _____

What is your reason for today's visit? _____

Is today's visit the result of an accident or injury? Yes _____ No _____

Date of accident _____

Any other liable party from accident? _____

GENERAL MEDICAL HISTORY

Check all that apply

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Disorders |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Eye Trouble | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Other _____ |

Operations/Hospitalizations

Year Conditions

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a Living Will? yes no

I hereby assign to Advanced Foot & Ankle Specialists, P.A. all payment for medical services rendered to myself or my dependent listed above. I understand that I am responsible for any amount not covered by insurance. I also authorize release of medical information necessary to process any health insurance claim.

Signature _____ **Date** _____

ADVANCED FOOT & ANKLE SPECIALISTS, PA

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name: _____ **Date of birth:** _____

I hereby authorize **Dr. Weingarten and/or Advanced Foot & Ankle Specialists, PA** to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Specific persons/organizations to receive the information _____

The specific information to be released/disclosed is specified below:

Complete Medical Record

Or specify one or more of the following:

- Operative Reports
- Progress Notes
- Laboratory
- X-rays
- Billing and Claim Records
- (Other – specify)

This information is to be used/disclosed for the following purposes(s) only: _____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

****You are entitled a copy of this document****

Signature of patient or patient's representative

(Form MUST be completed before signing.)

Date

Printed name of patient's representative (if applicable): _____

Relationship to the patient (if applicable): _____

Advanced Foot & Ankle Specialists, P.A.
Jay S. Weingarten, DPM, FACFAS, FACFAOM
Podiatric Physician & Surgeon

**Acknowledgment of receipt of
Notice of Privacy Practices**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

Patient Name (Print)

Date

Parent, Guardian or Patient's Legal Representative

Signature

Advanced Foot & Ankle Specialists, P.A.
Jay S. Weingarten, DPM, FACFAS, FACFAOM
Podiatric Physician & Surgeon

Private Insurance, PPO, HMO, and EPO/POS Plans and Self Pay

1. This office will file your insurance. You are responsible for all co-payments, deductibles and non covered services. Our office does NOT verify insurance following the initial visit. **It is your responsibility to report insurance changes to us promptly to avoid claim denials (as Florida has time limits for filing claims).**
2. Co-pays, deductibles and non-covered charges are due at time of service. We accept cash, check and major credit cards for payment of charges.
3. Returned checks are subject to additional fees as per Florida Statutes. Balances over 90 days may be subject to additional interest of 1.5% per month. Accounts over 120 days will be placed with an outside collection agency unless prior arrangements are made with the office. Accounts sent to a collection agency will incur an additional collection fee of 35% of their outstanding balance.

We are confident that, by being participating providers, we will be able to provide excellent comprehensive podiatric services to our insurance patients.

Thank you for your cooperation.

Signature of patient or patient representative

Date

Relationship of representative

