Foot and Ankle Excellence
Dr. Bruni Leka, DPM, AACFAS, FACFAOM
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Patient Registration Forms:

Demographic Information:

Last Name: _____ First Name: _____ Middle: __
Date of Birth: _____(mm/dd/yyyy) Sex: _____ Race: _____
Social Security: _____ Ethnicity: _____
Address 1:_____, Address 2: _____
City: _____ State: _____ ZIP: _____
Preferred Language: _____ Marital Status:_____

Contact Information:

Cell Phone: _____ Work Phone: _____ Ext:_____
Home Phone: _____ Email: _____

Emergency Contact:

Contact First Name: _____ Last Name: _____
Home Phone: _____ Cell Phone: _____
Relationship to patient: _____
Address: _____

Primary Care Physician/Other Specialists:

Physician Name: _____ Phone: _____
Address: _____

Pharmacy: _____ Phone number: _____
Address: _____

Patient Communication Form:

Patient's Name: _____ **Date:** _____

Please describe your complaint (Be as detailed as possible):

How long has problem been present?

What specific incident started this complaint?

If **Pain** is involved, on a scale of 0-10, where 0 is no pain and 10 is the most severe/ excruciating pain) how severe is your discomfort? ____/10

What treatment have you tried previously?

Please check here if you have **Diabetes**: ____ Yes, ____No

If yes, What is your last **Hemoglobin A1C**? _____

Have you ever seen a Podiatrist/ Foot and Ankle Specialist before? ____ Yes, ____No

If yes, Please list name and date of last visit: _____

Please list all your **Medical Problems**:

Please List all your Previous **Surgeries**, from birth up to now:

Any **Family History** involving your Parents/Siblings/Immediate Relatives?

Do you currently **smoke**? ___Yes, ___No

Have you ever smoked?___Yes, ___No; If yes, for how long?_____

Do you or have you ever used any **illicit drugs**? ___Yes, ___No

Do you drink **alcohol**? ___Yes, ___No

If yes, how often? ___Rarely, ___Occasionally, ___Often, ___Every Day

How much alcohol do you consume? _____

Please list all your **Medications**, including vitamins and supplements:

Please List any known **Allergies**:

Your **Height:** _____ Your **Weight:** _____

How did you hear about us: _____

Employment Status:

___Employed, ___Unemployed, ___Student, ___Retired, ___Disabled
Highest Degree Earned: ___ High School, ___ College, ___ Graduate School
Occupation: _____,Employer's Phone: _____

Is visit related to a work injury? ____ Date of Injury: _____
Is this related to a Motor Vehicle Accident? ____ Date of Accident: _____

Your Insurance card and Photo ID are required at the time of your visit, along with the Co-Pay if any.

By signing below, I attest that the information provided above is true and accurate

Signature of Insured/Guardian: _____ **Date:** _____

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **Foot and Ankle Excellence** as your healthcare provider. We are committed to providing you with the highest quality of care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

We will bill your insurance for you. However, the patient is required to provide the most correct and updated insurance information at the time of the visit.

Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.

Co-pays are due at the time of service. Patient is responsible to obtain any required Referrals prior to their office visit through the PCP.

Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include: **Charge for Returned Checks or Missed appointments without 24 hours' prior notice (a $25 Fee applies).**

By my signature below, I hereby authorize assignment of financial benefits directly to Foot and Ankle Excellence, Inc and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understood, and agree to the provisions of the Patient Financial Responsibility Form

Signature of patient or Legal guardian: **Date**

_____ _____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize "**Foot and Ankle Excellence"** and **Dr. Bruni Leka**, to use and disclose the protected health information described below to:

_____
(**Doctor** / **Individual/family members** seeking information about your health).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ▫ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ▫ I authorize the release of my complete health record with the exception of the following information:

▫ Mental health records
▫ Communicable diseases (including HIV and AIDS)
▫ Alcohol/drug abuse treatment
▫ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Print Patient's Name:

_____

Signature of patient or personal representative: **Date:**

_____ _____