UNIVERSITY FOOT AND ANKLE INSTITUTE

PATIENT REGISTRATION FORM

PHYSICIAN:

- □ DR. GARY BRISKIN
- □ DR. BOB BARAVARIAN
- □ DR. JUSTIN FRANSON
- □ DR. DR. RYAN CARTER
- □ DR. BRAYTON CAMPBELL
- □ DR. STEPHEN SCHWARTZ
- □ DR. AVANTI REDKAR
- □ DR. JOHN CHAN
- □ DR. EVELYN HEIGH
- □ DR. ALI GHORBANI

LOCATION:

- □ SANTA MONICA
- □ BEVERLY HILLS
- □ SHERMAN OAKS
- □ VALENCIA
- □ WESTWOOD
- □ WEST HILLS
- □ SOUTH BAY
- □ SANTA BARBARA
- □ SIMI VALLEY
- □ MID WILSHIRE

PATIENT INFORMATION

LAST NAME	FIRST NAME		M.I.
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**WORK PHONE**	**CELL PHONE**	
SOCIAL SECURITY #	**SEX** M F	**DATE OF BIRTH**	**AGE**
EMAIL ADDRESS	**PLEASE CIRCLE THE BEST WAY TO CONTACT YOU** EMAIL HOME WORK CELL		

LANGUAGE □ ENGLISH □ SPANISH □ RUSSIAN □ OTHER

MARITAL STATUS □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

RACE/ETHNICITY □ AMERICAN INDIAN OR ALASKA NATIVE □ ASIAN □ HISPANIC □ WHITE □ BLACK
□ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER □ OTHER RACE □ UNREPORTED/REFUSE TO REPORT

EMPLOYER	OCCUPATION
PRIMARY CARE PHYSICIAN	**PHONE**
REFERRED BY	**PHONE**

INSURANCE INFORMATION

INSURANCE TYPE (CIRCLE) MEDICARE PPO POS EPO HMO WC SELF PAY OTHER

PRIMARY INSURANCE	ID#	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
SECONDARY INSURANCE	**ID#**	**RELATIONSHIP TO INSURED** SELF SPOUSE CHILD OTHER

INSURED INFORMATION (IF OTHER THAN PATIENT)

INSURED LAST NAME	INSURED FIRST NAME		INSURED M.I.
SOCIAL SECURITY #	**DATE OF BIRTH**	**INSURED PHONE**	
ADDRESS	**CITY**	**STATE**	**ZIP CODE**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize **University Foot & Ankle Institute** to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving it and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

□ By checking this box, I hereby authorize the use of my PHI for the purpose of diagnosing, treating, consulting and referral.

□ By checking this box, I hereby authorize the disclosure of my PHI to insurance carriers and/or its representatives for processing claims.

ASSIGNMENT OF BENEFITS

I hereby authorize payments to be made directly to University Foot & Ankle Institute for surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered. I understand that I am financially responsible for the charges not covered by this Authorization. I further agree, in the event of Non-Payment, to bear the cost of reasonable legal fees should this be required. A photocopy of this Assignment shall be considered as effective and valid as the original.

SIGNATURE X _____ DATE _____

IF MINOR, PARENT/GUARDIAN MUST SIGN

_____

PLEASE PRINT PARENT/GUARDIAN NAME

FINANCIAL POLICY

Thank you for choosing University Foot & Ankle Institute as your health care provider. We are pleased to be able to render services in the evaluation and treatment of your condition. Please understand that you will be financially responsible for charges that are not covered by your insurance. If you have any questions regarding your financial account with our office, please contact our billing department during normal business hours, at (310) 828-0011, option 4.

Your clear understanding of our Financial Policy is important to our professional relationship.

- We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered.
- If you do not provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We accept cash, check, or credit card (Visa, MasterCard, or Discover).
- Please notify us immediately if there are any changes to your insurance plan or your coverage.
- Co-payments and Deductibles are an agreement between you and your insurance plan, are your responsibility, and are not something we can negotiate.
- Co-payments are due at the time of service and charges to cover your deductible may be requested to be paid toward if it has not been satisfied.
- Medical records or copies of records can be provided at your request; please allow up to 5 (five) business days for records to be compiled. There may be a nominal fee for record copying.

SELF PAY

We expect full payment at the time of service unless prior arrangements have been made.

MEDICARE

We accept Medicare assignment. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.

HMO/PPO

We are providers for many insurance plans, but are not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you must have a current referral at the time of your visit in order to be seen, and for the visit to be covered under your plan. Without a proper referral, you may be responsible for charges incurred.

If you are a PPO member, you are responsible for co-payments, deductible, and co-insurance. Please confirm with your insurance that we are providers covered under your plan.

WORKERS' COMPENSATION

If you are consulting with us regarding a work-related injury, we require information for both your personal insurance coverage as well as your employer's Workers' Compensation insurance. Prior to being evaluated in our office, we need to have a letter or statement from Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. Your employer's human resources office should be able to assist you with obtaining this information. If payment is not received from these third parties within 90 days, we reserve the right to bill you directly.

HOSPITAL AND SURGERY CENTER CHARGES

In the event that you undergo surgery in a hospital or outpatient surgery center, separate charges will be made by the facility. Your podiatric physician with University Foot & Ankle Institute may be part owner or have financial interest in a surgery center where you will be having surgery.

UCR (USUAL AND CUSTOMARY RATES)

We are committed to provide the best treatments possible for our patients. Our fees for services rendered are usual and customary for our geographic area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check, or credit card. Past due balances may be subject to additional fees.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed in a timely manner, to ensure that payment for services rendered. I understand that I am ultimately responsible for payment of all services.

PATIENT OR GUARDIAN NAME (PLEASE PRINT):	
SIGNATURE:	**DATE:**

LEGAL ASSIGNMENT OF BENEFITS
AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

In consideration of the health care services to be rendered by University Foot and Ankle Institute ("Provider") to me, I hereby represent and agree as follows:

All information I have provided to Provider in connection with the health care services to be rendered to me by Provider, including without limitation medical, financial, health care benefit plan, employee benefit plan, insurance coverage and worker's compensation and third party liability and claim information, as applicable, is accurate, complete and not misleading. I will promptly inform Provider of any change in the information that I have given.

Unless I am a Medicare or Medi-Cal beneficiary, I understand that I am legally and financially responsible to Provider for all charges for health care services rendered to me by Provider regardless of my insurance coverage, participation in a benefit plan, entitlement to worker's compensation benefits or third party liability.

I authorize and direct my insurer, benefit plan, plan administrator, plan fiduciary, third party administrator, attorneys, agents, successors in interest and personal representatives to release and disclose to Provider any insurance policy, description of coverage, benefit plan, explanation of benefits, audit or other information related to my insurance, benefits or other rights promptly upon Provider's written request. I will promptly furnish to my benefit plan or insurer any information it requests to confirm that I have designated Provider as my authorized representative and that Provider is authorized to act on my behalf in accordance with this assignment.

I assign and convey directly to Provider, as my designated authorized representative, all medical and other health care benefits, insurance payments and any other payment or reimbursement for health care services rendered to me by Provider, regardless of its managed care network participation or contract status. Upon Provider's request, I will instruct my benefit plan, insurer or other third party payer to deliver payment directly to Provider for all health care services rendered to me by Provider. If my benefit plan, insurer or other third party pays me for health care services rendered to me by Provider, I will immediately endorse and deliver to Provider, or otherwise cause to be paid to Provider, any such payment. Upon Provider's request, I will account to Provider for all amounts received and will deliver to Provider all explanation of benefits and other information I receive regarding such payments.

To the full extent permitted by law, including without limitation 29 U.S.C. sections 1132(a)(1) and 1132(a)(3), I assign and convey directly to Provider any legal, administrative or contractual claim pursuant to any group health plan, benefit plan, health care insurance or third party liability insurance concerning medical expenses incurred as a result of the health care services that I will receive from Provider, including any right or power to pursue such claim. I expressly and knowingly assign any ERISA breach of fiduciary duty claim and any other statutory, regulatory, administrative or other legal claim to Provider. I will promptly furnish information to, and otherwise cooperate reasonably with Provider, in its assertion of any such claim.

I intend by this assignment and designation of authorized representative to convey to Provider all of my rights and powers to claim or place a lien on the health care benefits, insurance payments and reimbursement related to the services rendered to me by Provider, including any benefits, insurance proceeds, damages (expressly including damages arising from ERISA breach of fiduciary duty claims), settlement proceeds or legal or administrative remedy. As my assignee and/or designated representative, I grant to Provider the right to initiate, prosecute and defend to any claim, appeal, legal action or administrative proceeding in any federal, state or other forum and to (1) obtain information regarding the claim to the same extent as I am entitled; (2) conduct discovery and obtain and submit evidence; (3) make allegations and statements about facts or law; (4) make any request or motion and provide and receive notices; (5) assert in its own name as assignee or otherwise participate in any claim, appeal, legal action or administrative proceeding against any insurer, employee benefit plan, health care benefit plan, plan administrator, plan fiduciary or other party. As my assignee and my designated authorized representative, Provider may initiate any legal action or administrative proceeding against any such insurer, employee benefit plan, health care benefit plan, plan administrator or other responsible party in my name at Provider's expense.

I intend for these agreements, assignments and designations to conform to all applicable laws and regulations regarding the subject matter. Any non-conforming provision shall be deemed severed, and the remaining provisions shall remain in full force and effect. Unless revoked, this assignment is valid for all administrative and legal proceedings under Patient Protection and Affordable Care Act, ERISA, Medicare, Medi-Cal and applicable federal and state laws and regulations. A photocopy or facsimile or other electronically transmitted image of this assignment is as valid as the original.

If Provider prevails in any action or proceeding to enforce any provision of the foregoing representations, assignment and designation of authorized representative, the Provider shall recover its attorney and expert witness fees and costs.

I have read and fully understand this Legal Assignment of Benefits and Designation of Authorized Representative form.

Patient Name: _____ Signature: _____

Name of Guardian (*if applicable)*: _____ Date: _____

UNIVERSITY FOOT & ANKLE INSTITUTE
FINANCIAL POLICY CHANGE

As of April 15, 2013, University Foot and Ankle Institute has made changes to their Financial Policy.

We ask that all patients leave a credit card number on file with our office. The card will only be used for patient accounts that are more than 30 days over due

Claims will be submitted to your insurance company, monthly statements will be mailed to you and payment arrangements can be worked out as we had done in the past. Once claims have been submitted to your Insurance Company, you should receive an "EOB" (explanation of benefits) regarding your visits and charges from our office.

The credit card will be used in the event that we have been unable to collect or make payment arrangements with you and your account is more than 30 days overdue. Once you receive a statement with a balance due, we will allow a 30 day period for payments to be made. If no payments have been made, and no arrangements are made with our billing office, we will charge the balance to your credit card. After your credit card is charged, a receipt will be mailed to you for your records.

An annual interest of 20% might be added to all your outstanding balances.

I, (please print name _____ have read and understand the above mentioned policy and agree to leave my credit card on file. ***I authorize University Foot and Ankle Institute*** to charge my credit card for payments owed to my account for services rendered at their office, in the event my account becomes overdue past 30 days. I agree to update any information regarding this account. The above information is complete to the best of my knowledge.

I, (please print name _____ decline to leave my credit card on file. I understand that I will need to pay upfront an estimate of the co-insurances or deposit for services provided today. Once claims have been processed and settled with my insurance company I will be refunded if my account has any credit due, back to me.

_____ _____

Patient's Signature Date:

_____ _____

Parent/Guardian's Signature: (If Minor) Date: