UNIVERSITY FOOT AND ANKLE INSTITUTE

PATIENT REGISTRATION FORM

PHYSICIAN:

- □ DR. GARY BRISKIN
- □ DR. BOB BARAVARIAN
- □ DR. JUSTIN FRANSON
- □ DR. AVANTI REDKAR
- □ DR. RYAN CARTER
- □ DR. STEPHEN SCHWARTZ
- □ DR. JOHN CHAN
- □ DR. CYRUS SIRCAR
- □ DR. HEAMIN SHIN

LOCATION:

- □ SANTA MONICA
- □ BEVERLY HILLS
- □ SHERMAN OAKS
- □ VALENCIA
- □ WESTWOOD
- □ DOWNTOWN
- □ 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:**

UNIVERSITY FOOT & ANKLE INSTITUTE
MEDICAL HISTORY FORM

PATIENT NAME	DATE OF BIRTH

CHIEF COMPLAINT HISTORY

PLEASE DESCRIBE THE REASON FOR YOUR VISIT:

DATE OF INJURY/ONSET OR DURATION:

DESCRIBE YOUR SYMPTOMS: □ PAIN □ SWELLING □ BURNING □ TINGLING □ NUMBNESS □ PAIN AT REST □ PAIN WITH ACTIVITY □ OTHER SYMPTOMS:

WHAT TREATMENTS HAVE YOU TRIED? □ ORTHOTICS □ MEDICATIONS □ INJECTIONS □ PHYSICAL THERAPY □ SURGERY □ OTHER TREATMENTS:

HEALTH HISTORY

□ ARTHRITIS □ RA TYPE:	□ GOUT	□ DIABETES □TYPE 1 □TYPE 2	□ NEUROPATHY	□ LOW BACK PAIN
□ STROKE	□ CANCER TYPE:	□ CHEMICAL DEPENDENCY	□ ASTHMA	□ RESPIRATORY PROBLEMS
□ KIDNEY DYSFUNCTION	□ LIVER DISEASE	□ HEPATITIS	□ LOW BLOOD PRESSURE	□ HIGH BLOOD PRESSURE
□ CIRCULATION PROBLEMS	□ HEART PROBLEMS	□ ARTIFICIAL HEART VALVE	□ CHF	□ EPILEPSY
□ OBESITY	□ WEIGHT LOSS, UNEXPLAINED	□ AIDS/HIV	□ FAINTING	□ FIBROMYALGIA

MEDICATIONS, WITH DOSAGE (PLEASE INCLUDE OTC MEDS)

PHARMACY (NAME & LOCATION)	PHONE	FAX

ALLERGIES

□ PENICILLIN	□ LATEX	□ LOCAL ANESTHETIC	□ CODEINE
□ SULFA	□ IODINE □ SKIN □ IV	□ NOVOCAINE □ LIDOCAINE	□ ANTI-INFLAMMATORIES
□ SEAFOOD	□ ADHESIVE/TAPE	□ GENERAL ANESTHESIA	□ ASPIRIN
□ OTHER:			

SURGICAL HISTORY

SURGICAL PROCEDURE	YEAR	SURGEON or HOSPITAL	COMPLICATIONS?

----------BACK-----→

SOCIAL HISTORY

TYPES OF EXERCISE:

ARE YOU PREGNANT? □ YES □ NO	**SHOE SIZE**:	**HEIGHT:**	**WEIGHT:**

DO YOU DRINK ALCOHOL? □ NEVER □ QUIT □ OCCASIONALLY □ REGULARLY □ HEAVILY

DO YOU SMOKE? □ YES □ NO IF YES, PACKS PER DAY:

FAMILY HISTORY

MOTHER: □ ALIVE □ DECEASED ANY SIGNIFICANT MEDICAL HISTORY?

FATHER: □ ALIVE □ DECEASED ANY SIGNIFICANT MEDICAL HISTORY?

SIBLING: ANY SIGNIFICANT MEDICAL HISTORY?

REVIEW OF SYSTEMS

PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST 3 MONTHS

GENERAL	□ FEVER	□ CHILLS	□ FATIGUE	□ WEIGHT GAIN/LOSS
HEAD	□ HEADACHES	□ VISUAL PROBLEMS	□ HEARING PROBLEMS	□ NECK PAIN
CARDIOVASCULAR	□ CHEST PAIN	□ PALPITATIONS	□ DIZZINESS UPON STANDING	□ LEG PAIN WHEN WALKING
HEMATOLOGY	□ ABNORMAL BLEEDING	□ BRUISING	□ BLOOD CLOTS	□ DELAYED HEALING
RESPIRATORY	□ PERSISTENT COUGH	□ WHEEZING	□ SHORTNESS OF BREATH	□ PAIN ON BREATHING
GASTROINTESTINAL	□ DIFFICULTY SWALLOWING	□ INDIGESTION OR HEARTBURN	□ ABDOMINAL PAIN	□ CHANGE IN BOWEL HABITS
URINARY	□ PAIN ON URINATION	□ FREQUENT URINATION	□ ICONTINENCE	□ BLEEDING ON URINATION
MUSCULOSKELETAL	□ JOINT PAIN OR SWELLING	□ JOINT STIFFNESS	□ CRAMPING	□ WEAKNESS
SKIN	□ SKIN RASH	□ ABNORMAL SKIN LESIONS	□ ITCHING	□ WOUNDS OR ULCERS
NEUROLOGICAL	□ NUMBNESS	□ SEIZURES	□ TREMORS	□ PARALYSIS
PSYCHIATRIC	□ DEPRESSION	□ ANXIETY	□ INSOMNIA	□ MEMORY LOSS
ENDOCRINE	□ HEAT/ COLD INTOLERANCE	□ HOT FLASHES	□ CHANGE IN HAIR/ SKIN TEXTURES	□ EXCESSIVE SWEATING

CONSENT FOR TREATMENT

THE INFORMATION PROVIDED HERE IS TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE RELEASE OF ANY PREVIOUS MEDICAL RECORDS BY FAX, MAIL, OR PHONE TO EITHER A TREATING PHYSICIAN OR HOSPITAL. I ALSO GIVE PERMISSION TO THE PHYSICIAN OR HIS ASSISTANT(S) TO INITIATE THE DIAGNOSIS AND TREATMENT OF MY CONDITION WITH EXAMINATION, IMAGING STUDIES, AND/OR PHOTOGRAPHS AS DEEMED MEDICALLY RELEVANT AND NECESSARY.

SIGNATURE X_____ DATE: _____

IF MINOR, PARENT/GUARDIAN MUST SIGN

_____

PLEASE PRINT PARENT/GUARDIAN NAME

PLEASE STOP HERE

For office use only:

PHYSICIAN STATEMENT

I HAVE PERSONALLY REVIEWED THE ABOVE INFORMATION.
PHYSICIAN 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: _____

UFAI UNIVERSITY FOOT & ANKLE INSTITUTE

Authorization to release information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information discussed with family members you must sign this form.

By signing this form you only give your consent to discuss your medical and billing information with the family members indicated below.

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Patient Name: _____

Patient Signature: _____

Authorization to leave messages with Household members / Cell Phone / Answering machine:

Occasionally it is necessary for the staff of University foot and Ankle Institute to leave messages for patients. The purpose of these messages might be to remind patients of their upcoming appointments or leave messages to return our calls to discuss test results. At no time will a representative of University Foot & Ankle Institute discuss your medical condition without your consent.

By signing this form you only give your consent to leave messages with members of your household or on your personal cell phone or on your answering machine. You have the right to revoke this consent in writing at any time.

Patient Name: _____

Patient Signature: _____

UNIVERSITY FOOT & ANKLE INSTITUTE

Changes to our Credit card on file Policy

To Our Patients:

As of February 01, 2018 this office will require you to leave a credit card on file.

Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. What we are doing is nothing different than a hotel or rental Car Company does at each check-in. All credit card contracts give cardholders the right to challenge any charge against their account.

FAQs

What is a Deductible and How Does It Affect Me?
An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay.

For example, if the policy has a $500 deductible, you must pay the first $500 of medical expenses before the insurance company begins to pay for any services.

When do I have to pay for services?
Any time you receive medical care, you are expected to pay in full for your services until your deductible is met.

How will I know when my deductible has been met?
Call your insurance company at any time to check on how much of your deductible has been met; some insurance companies have this information available online. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay. As a service to our patients, we try our best to verify the benefits for you as well.

How will I know how much is being charged on my credit card
For every visit or surgery, your insurance company mails an Explanation of Benefits (EOB) to you. This document shows how much your insurance paid and what you need to pay based on the benefits of your policy. This office receives the same information that you do from your Insurance Company. We apply the payment (if any) and make any discount or adjustment as per our contract with your insurance company. The balance on your account for that visit or surgery will then match the patient responsibility amount on your EOB. This is the amount that will be charged to your credit or debit card. A receipt will be sent to you via email.

What if I have 2 insurance plans?
You are very fortunate!! Each plan may have different policy benefits and deductibles. Again, we will ask that you put a credit or debit card on file just in case these plans do not cover all your services. Remember, we will not access this information until both plans have paid AND if there is a remaining patient responsible balance.

I don't really know my insurance benefits. Can you tell me what they are?
Unfortunately, there are SO many health plans that we are not able to know them all. We do try our best to verify that insurance plans are effective and what the status of your deductible, coinsurance and co pay may be, but we do not always know the exact benefits of your plan.

I've never had to do this before at any other doctor's office
This may be a departure from what you have been used to but it is not uncommon in many medical practices, imaging centers, outpatient surgical centers require a credit card on file.

Why I'm being singled out? I always pay all my bills.
All patients are required to keep a credit or debit card on file. This policy isn't personal; we apply it equally to all of our patients; by doing it this way, the temptation to play favoritism is eliminated and it removes us from the uncomfortable situation of having to decide who has to follow the policy and who does not.

What about identity theft and privacy?
Under HIPAA, we are under strict rules and guidelines in terms of protecting patient privacy and the credit card is considered protected health information. Because of HIPAA rules, our medical office is far more secure than most retail establishments as it relates to identity theft.

I don't have a credit card.
You are welcome to leave a debit card, HSA(Health Savings Account) or Flex Plan card on file or pay with cash or check for the visit in full.

This is NOT the same as "balance billing"
"Balance billing" is asking the patient to pay the difference between our normal fee and the insurance company's normal payment. That's a breach of our insurance contracts. What we charge to the patient's credit card is the portion the insurance company determined is not covered by the company. For example if your Insurance approves $100, and pays 80% of that amount the other $20 is the patient 's responsibility, and is what we charge to the credit card – instead of sending out a statement for that amount.

Credit Card on File Agreement

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.

_____ _____
Patient's Signature Date:

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

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 or will be charged any additional balance the insurance makes me responsible for.

_____ _____
Patient's Signature Date:

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