



## Billing Policy

The following sets forth the general billing policy of Dr. Arthur Fass. Please review this information and sign where indicated.

- ❖ I understand that it is my responsibility to provide the office of Dr. Arthur Fass with current, accurate billing information at the time of check in and to notify the office of any changes in this information.
- ❖ I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$35 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- ❖ I understand that there is a \$20 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms ( such as FMLA) require completion, I understand that the \$20 fee (payable prior to completion) is required.
- ❖ I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.
- ❖ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- ❖ I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- ❖ I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to Dr. Arthur Fass.

X  
\_\_\_\_\_  
Legal Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

**Dr. Arthur Fass**  
**Podiatric Medical Corp.**  
**Sports Medicine - Foot Surgery**

*Welcome to Our Office*

DATE: \_\_\_\_\_

**Please print clearly.**

**The following information is important. Your cooperation is appreciated**

LAST NAME	FIRST NAME	MIDDLE	AGE	BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
NAME OF MEDICAL DOCTOR		ADDRESS			DATE OF LAST EXAM
I AM ALLERGIC TO: <input type="checkbox"/> LOCAL ANESTHETIC (THE CAINES) <input type="checkbox"/> ANTIBIOTICS <input type="checkbox"/> ASPIRIN <input type="checkbox"/> FOODS <input type="checkbox"/> PENICILLIN <input type="checkbox"/> CODEINE <input type="checkbox"/> TAPE <input type="checkbox"/> NONE <input type="checkbox"/> OTHERS:				HEIGHT	WEIGHT

WHAT MEDICINES ARE YOU NOW TAKING?

PREVIOUS OPERATIONS AND DATES:

SERIOUS ACCIDENTS OR DISABILITIES AND DATES:

MY CHIEF FOOT AND ANKLE COMPLAINT IS:

Do you have or have you had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Severe Infections	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Others:	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Intestinal Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Foot or Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____		

I hereby give my permission to DR. ARTHUR FASS and his staff to administer treatment and medications and to perform such procedures as may be deemed necessary or advisable in the diagnosis and/or treatment. I understand that I am responsible for any fees, regardless of insurance coverage, and that it is customary to pay for all professional services on the date they are rendered, unless other arrangements have been made.

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Referred By: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

*Dr. Arthur Fass  
Podiatric Medical Corp.  
18250 Roscoe Blvd. #125  
Northridge, CA 91325  
(818) 701-5088*

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician Certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Signature:   X   \_\_\_\_\_  
Date: \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:
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