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

Patient Registration **(PLEASE PRINT CLEARLY!)**

Date: _____

Patient's Name: _____ SS #: _____
First Name MI Last Name

Date of Birth: _____ __Male __ Female __Single __Married __Widowed __ Divorced __ Separated

Street Address : _____

City/State/Zip Code: _____ Home Phone w/Area Code: _____

Cell Phone w/Area Code: _____ Email: _____

Spouse's Name: _____ SS #: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Patient's Employer: _____ Work Phone w/Area Code: _____

Credit: (Circle) MC Visa # _____ Exp ___/___/___ Name on card _____

Responsible Party: _____ Relationship: __Self __Spouse __Parent __Other: _____

If patient is a Minor, are parents __Married __Divorced Custodial Parent: _____

Custodial Parent's Home Phone w/Area Code: _____ Work Phone w/Area Code: _____

Custodial Parent's SS #: _____ Date of Birth: _____

In case of emergency, contact (not living with you): _____

Phone Number w/Area Code: _____ Relationship to Patient: _____

Is this work-related? __Yes __No If yes, date of injury? _____ Claim #: _____

How did this injury happen? _____

_____

Referring Physician's Name & Phone Number: _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Insurance Company # 2: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

If you do not have insurance, have you applied for Medicaid? __Yes __No If yes, what is the name and phone number of the social worker with whom you are working? _____

- I hereby authorize the payment of medical benefits to Dr. Arthur Fass. for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize Dr. Arthur Fass to release any medical information necessary to complete and process my insurance claims.

>> _____ _____

>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

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I authorize Dr. _____ to treat me and use my personal health information for healthcare operations.

>> _____ _____

>>*Patient's Signature* (OR Parent if patient is a Minor) Date

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.

_____ _____

Legal Signature Date

_____

Relationship to Patient

ARTHUR H. FASS, DPM
18350 ROSCOE BLVD. #707
Northridge, CA 91325-4280
office: (818) 701-5088 fax: (818) 701-1602

1. Patient Name: _____ Date: _____

(2. Time Taken: _____ 3. BP: ____/_____ 4. BPM: _____) SKIP –

6. Height: _____Ft. _____in. 7. Weight: _____LBS 8. Shoe Size: _____

9. Preferred Language: _____ 10. MALE / FEMALE

11. Race: (please circle most accurate)

a. American Indian or Alaska Native b. Asian c. AfricanAmerican

d. Native Hawaiian e. Pacific Islander f. White/Caucasian

e. Other

12. Ethnicity: (please circle most accurate)

Hispanic or Latino or Non-Hispanic or Non-Latino

13. MEDICATIONS: (you may continue on back)

Name of Medication	Dosage	Pt. Indications

14. ALLERGIES:

Type of Allergy	Severity	Reaction

Patient Name: _____ AGE: _____ DOB: _____

16. Are You A Diabetic?

a. YES b. NO For How Long? _____

CONTINUED MEDICATIONS:

Name of Medication	Dosage	Pt. Indications

CONTINUED ALLERGIES:

Type of Allergy	Severity	Reaction

17. PRIMARY CARE PHYSICIANS INFORMATION:

Name: _____ Phone: _____

Address: _____ Last Date You Saw Your PCP:

_____ _____

18. Please Circle if you have any of the following :

Tuberculosis Thyroid Disorders Bleeding Disorders Exposure to AIDS

Malaria Anemia Severe Headaches Asthma Gout Leukemia

Mental Illness Arthritis Glaucoma Blood Disorders Severe Infections

Liver Disease HighBP Polio Skin Disease Heart Disease

Varicose Veins Syphilis Kidney Disease Thrombophlebitis

Gonorrhea Intestinal Disorders Stroke Cancer

StomachUlcers Foot or Leg Cramps Epilepsy

MAIN FOOT AND ANKLE COMPLAINT:

_____

_____

_____

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: _____

Date: _____

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: