FOR OFFICE USE ONLY
LOCATION:

REGISTRATION FORM

(Please print clearly)

Preferred Comunication ___e-mail____home___cell___work

Today's Date // PLEASE FILL IN DATE

PATIENT INFORMATION

Patient's Last Name	First	Middle	
Street Address	City	State	Zip Code
Home Phone # ()-	Work Phone # ()-	Cell Phone # ()-	Email Address:
Date of Birth //	Age	Social Security # / /	Marital Status Single Married Widow Divorced
Gender M F			

INSURANCE INFORMATION

Occupation	Insured's Employer
Insured's Employer's Address	

Please indicate primary insurance:

Insured's Name	Insured's S. S. #	Insured's ID	Co-Payment Amount $

Patient's Relationship to Insured Self Spouse Child Other **Insured's Birth Date //**

Please indicate secondary insurance:

Insured's Name	Insured's S. S. #	Insured's ID	Co-Payment Amount $

Relationship to Insured Self Spouse Child Other **Insured Birth Date //**

Does your plan require a referral? Yes No **If Yes, was a referral obtained?** Yes No **Referral #:**

FAMILY PHYSICIAN INFORMATION

Medical Doctor's Name	Medical Doctor's Phone Number ()-		
Medical Doctor's Street Address	City	State	Zip Code
Date of last physical exam //	Date of last blood test //		

WHO REFERRED YOU TO OUR PRACTICE?

Doctor		Friend	
Hospital		Website	
Insurance Plan		Other	
Family			

MEDICAL HISTORY

PATIENT NAME				BIRTH DATE//
ALLERGIES *(LIST KNOWN ALLERGIES TO DRUGS/MEDICATIONS – AND SPECIFIC REATIONS TO THEM*				
Penicillin	Sulfa	Local Anesthetic	Iodine on Skin	Aspirin
Codeine	Tape	Anti-inflammatory Medication	Other:	
If any allergies, what type of reaction? Difficulty breathing Rash Stomach upset				

MEDICATIONS *CURRENT MEDICATIONS YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*			
MEDICATION	DOSE	MEDICATION	DOSE

FOOT AND ANKLE HISTORY			
What foot/ankle problem brings you to the doctor?	**How Long?**	Months	Years
How have you been treated for the current problem?			
Surgery	Orthotics	Oral Medications	Cortisone Shots
Do you have an X-Rays, MRI, or CT Scan for the current problem? Yes No			
Shoe size	**Height**	**Weight**	

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT					
Arthritis/Rheumatism	Yes	No	High Blood Pressure	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	High Cholesterol	Yes	No
Asthma	Yes	No	H.I.V. Positive	Yes	No
Cancer	Yes	No	Kidney Trouble	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Diabetic Foot Ulcers	Yes	No	Neurological Disorder	Yes	No
Fibromyalgia	Yes	No	Psychiatric/Psychological Care	Yes	No

Bleeding Disorders	Yes	No	Stomach Ulcers / Reflux / Heartburn	Yes	No
Heart Disease or Attack	Yes	No	Other:		
Heart Murmur	Yes	No	Other:		
Hepatitis (Indicate) A B C	Yes	No	Other:		
Do you drink?	Yes No	If Yes, Drinks per week			
Do you smoke?	Yes No	If Yes, Pack(s)/day			
Are you pregnant?	Yes No				

PATIENT NAME **BIRTH DATE**//

INDICATE ANY SURGICAL YOU HAVE HAD IN THE PAST

Orthopedic/Podiatric	Yes	No	Circulation (Bypass, Angioplasty)	Yes	No
Heart	Yes	No	Aneurysm	Yes	No
Tumor	Yes	No	Head and Neck	Yes	No
Abdominal	Yes	No	Other:		
Have you ever been put to sleep for surgery?	Yes	No	Any problems with anesthesia?	Yes	No

FAMILY HISTORY

Relative	*Alive*	*Deceased*	*Age Deceased*	*Cause of Death (Heart Problems, Cancer, Diabetes, Etc.)*
Father				
Mother				
Siblings				

MEDICAL HISTORY AFFIRMATION

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X_____

//

Advanced Foot and Ankle Center of San Diego
Philip Wrotslavsky, DPM,AACFAS
FINANCIAL POLICY AND PATIENT AGREEMENT

MEDICARE /PPO: We have enrolled in numerous insurance PPO programs, as well as Medicare. Due to the constant changes in healthcare today, it is difficult for us to monitor all the individual insurance companies we have contracts with, as well as the individual requirements of the plans. Each plan has different stipulations regarding our services, what, where, and how often those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract you or your employer has negotiated.

Our office has agreed to bill your insurance company for payment of your office visit/s. You, the patient, are responsible for all co-payment, coinsurance and deductibles specified by the insurance company. They are to be paid at the time of service. We will take the minimum that is generally allowed as a payment toward your deductible or coinsurance. If your insurance company allows additional payment or if your have additional procedures/services performed we will automatically charge your credit card for any balance due that is indicated on your explanation of benefits. You are also responsible for any services that your insurance does not cover, or for any balance due if we are out of network. Our office is not currently enrolled in any HMO plans. All HMO patients will be considered as cash patients and will be required to pay for the visit in full at the time of service

We will attempt to obtain authorization for certain services, but please understand that, you, the patient are responsible for understanding your own insurance plan and for checking if we are in-network with your insurance plan. If you booked an appointment and there is a balance owed, your credit card on file will be charged for the balance due.

PAYMENT OPTIONS: If you need assistance with insurance or referral problems, or wish to discuss your account and/or set up financial arrangement contact our billing department. (888) 451-3770. We accept cash, checks, or credit cards (Visa, MasterCard) as payment. We will take a credit card on file for any payments due. Once you sign this form please be aware that we will charge your credit card for any balance due only as stated on your explanation of benefits without further notice. You will receive a receipt for these charges. There will be a $25.00 service charge on any returned checks.

I understand and agree that there will be a charge on my credit card for services rendered by the Advanced Foot and Ankle Center after my insurance company sends an explanation of benefits indicating the balance owed. If the amount is over $500 I will receive a courtesy call to discuss payment plan options.

Patient Signature: _____ Date: _____

COPIES OF RECORDS: If you are in need of copies of your records, complete a release form, allowing enough time so that the records can be done. **Fees for copying records are $25.00.**

DISABILITY FORMS (ANY FORMS): **There is a $10.00 charge for completion of forms.** If you need a letter to be written by a physician, please allow 5-7 working days for completion.

PRESCRIPTIONS: Please give our office at least 24 hours' notice if you need a refill on your prescription during the workweek. Please call by noon on Friday for refills needed during the weekend. *No Refills After Hours.*

I am aware that the physician may take photographs or videos of my feet/toes/lower extremities. Once, I allow the physician to take photo's or video's in the office, I am aware that they may be utilized in brochures, publications, medical conferences or on the physicians website etc. No names or personal information of any kind will be attached for confidentiality purposes.

Patient Signature: _____ Date: _____

Philip Wrotslavsky, DPM, A Professional Corporation

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services and benefit due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment (including to my insurance company).

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize Philip Wrotslavsky, DPM, APC to use and disclose any of my personal, health, treatment, and payment information for health care operations purposes. This includes any and all information requested by the insurance companies which are necessary to collect benefits under these policies which are in effect at the time of treatment or any policies which I subsequently make claim against for hospital services, including related physician's services on this date of service or related date of service. Unless noted below, this authorization includes but is not limited to the release of information related to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing. I further authorize any physician or institution that attended to this patient previously to furnish medical records to Dr. Wrotslavsky and authorize the release of information which may be requested by Philip Wrotslavsky, DPM A Professional Corporation from any provider related to my medical care and medical billing.

Signature: _____ Date: _____

CONSENT FOR MEDICAL AND SURGICAL TREATMENT: I authorize Philip Wrotslavsky, DPM, APC to furnish the necessary medical or surgical treatment, or procedures, including diagnostic x-ray and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of the treatment. I recognize that Dr. Philip Wrotslavsky is an independent physician at 15525 Pomerado Road Suite E-6 San Diego, California 92064. I understand this and have accepted this without any reservation.

Signature: _____ Date: _____

IF PATIENT IS UNDER 18:

I hereby give my permission for _____ to be treated at the Philip Wrotslavsky, DPM, A Professional Corporation.

Guardian Name: _____

Guardian Signature: _____ Witness: _____ Date: _____

The appropriate authorizations must be signed in order to expedite the filing of your insurance claim.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as o medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim, in the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physicians partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated n writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention an joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services. _____
Patient's or Patient's Representatives Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRAIL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Duly Authorized Representative (Date)

Philip Wrotslavsky, DPM, A Professional Corporation
Philip Wrotslavsky, DPM 15525 Pomerado Rd., Ste. E-6, Poway, Ca. 92064
Print or Stamp Name
Medical Group or Association Name

By: _____
Signature of Translator (If applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
Patient's Representative's Signature (Date)

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Patient's Name: Medicare # (HICN)

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for –

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: $_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

☐ **Option 1. YES.** I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO.** I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date _____ Signature of patient or person acting on patient's behalf _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Philip Wrotslavsky, DPM, A Professional Corporation
15525 Pomerado Road, Suite E-6
Poway, CA 92064

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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:_____

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

* Worker's Compensation

You have signed a waiver starting your worker compensation claim. You have waived your rights in viewing the chart. Contact your Attorney or Insurance adjuster for any copy of records.

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