BREGMAN
FOOT-ANKLE & NERVE CENTER

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Bregman Foot Ankle & Nerve Center ("BFANCE") as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

The patient (or the patient's parent/guardian/healthcare proxy/power of attorney) is ultimately responsible for the payment of his/her treatment and care. As a courtesy, we are pleased to assist you by billing our contracted insurers. However, the patient is required to provide us with the correct information about their insurance. The patient will be responsible for any charges incurred if the information provided is not correct or updated.

Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service. For your convenience, we accept cash, cashier's check, and most major credit cards at our office. • Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing.

By my signature below, I acknowledge and understand that missed appointment without 24-hours advance notice will incur a $50 fee which must be paid IN-FULL before future appointments are scheduled.

Patients may incur and are responsible for the payment of additional charges at the discretion of BFANCE. These charges may include (but are not limited to): Charge for returned checks ($40-forty dollars). Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions. Charge for the copying and distribution of patient medical records (sixty cents per page). Charge for processing FMLA forms or Short-Term Disability forms ($50-fifty dollars), processing additional forms ($25 twenty-five dollars). Charge for purchase of Durable Medical Equipment or Over-The-Counter products. Charge for in-office procedures or injections not covered by insurance. Any costs associated with collection of patient balances. Prior to surgery, if you have a significant deductible, you will have to pay at least 40% of your deductible for the procedure.

By my signature below, I hereby authorize BFANCE and the physicians, staff, and hospitals associated with BFANCE to release medical and other information acquired during my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care. • I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverages, deductibles, and payments. • I hereby authorize assignment of financial benefits directly to BFANCE and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Please understand that it is ultimately the patient's responsibility to know his/her own insurance coverage. If you dispute your benefit coverage in any way, please contact your insurance company. Please be advised, some services will require prior authorization. Even though a service has been prior approved, this is not a guarantee of benefits or payment to our facility. Therefore, if you do not have the benefits for the services rendered, you will be responsible for all charges incurred on that date of service. Please be advised that a new treatment cycle cannot be started until any previous account balances have been paid in full.

By my signature below, I agree to accept full financial responsibility as a patient or as the responsible party who is receiving medical services. I agree to keep my account in good standing. I acknowledge and I understand that outstanding balances must be paid before receiving additional services. I understand that unpaid balances will be sent to collections. My signature verifies that I have read the above financial policy, I understand my financial responsibilities, and I agree to these terms.

_____	_____	_____
Signature of Patient or Responsible Party	Print Name:	Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ PATIENT DOB: _____

ADDRESS: _____ PATIENT PHONE: _____

Please Note: a printing fee may be charged to print your Medical Records

I authorize the following agencies and/or individuals to make a record disclosure:

NAME OF OFFICE (preferred) AND/OR DR.: _____

ADDRESS: _____

PHONE#: _____ FAX#: _____

I authorize the agencies and/or individuals above to release information to:

BREGMAN FOOT-ANKLE & NERVE CENTER **PHONE: 702-703-2526**

7150 W SUNSET RD #110 LAS VEGAS, NV 89113 **FAX: 800-638-8056**

Purpose for disclosure of Medical Records: ☐ Continuity of care ☐ Change of Insurance/Provider ☐ Referral ☐ Other

Specific description of the information to be released:

☐ ALL RECORDS	☐ RADIOLOGY REPORT	☐ LAB REPORT	☐ EMG/NCV REPORT
☐ OPERATIVE REPORT	☐ CLINICAL NOTES	☐ DATES:	
☐ OTHER:			

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Authorization expiration date: _____

Notice to Patient: My consent will expire on the date noted above unless I withdraw my consent. If the expiration date is blank, the consent will expire 1 year from the signature date. Notice to Patient: I understand that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, but in that event, information cannot and will not be released. I also understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization if the Privacy Rule prohibits such conditioning. I also understand that treatment by this provider is not conditioned on my signing this authorization, although exceptions will be made for a) research related treatment and b) psychotherapy notes. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and may no longer be protected by federal privacy regulations. I acknowledge that I have the right to revoke this authorization at any time, and I understand that once the information is disclosed, it may no longer be protected by the HIPAA Federal Privacy Law. I may revoke this authorization in writing, in person, or by certified mail to the provider at the address above. The revocation will be effective only upon receipt, except to the extent that the Provider has acted in reliance on the authorization. Further information on the right to revoke may be provided from time to time in the Provider's Notice of Privacy Practices.

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered. I have read the above foregoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

SIGNATURE OF PERSON GIVING CONSENT OR LEGAL REPRESENTATIVE

PRINT NAME OF PERSON GIVING CONSENT OR LEGAL REPRESENTATIVE

_____ _____

RELATIONSHIP

DATE

PATIENT REGISTRATION

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR APPOINTMENT.

DEMOGRAPHICS:

LAST NAME: _____ FIRST NAME: _____ MI:_____

DATE OF BIRTH: _____ (MM/DD/YYYY) GENDER: _____ SSN#:_____

RACE: _____ ETHNICITY: _____ LANGUAGE:_____

ADDRESS 1 : _____ ADDRESS 2:_____

CITY:_____ STATE:_____ ZIP:_____

CONTACT INFORMATION:

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT:

RELATIONSHIP: _____ FIRST/LAST NAME:_____

CELL PHONE:_____ HOME PHONE:_____

ADDRESS: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ UNEMPLOYED ☐ FULL-TIME / PART-TIME STUDENT ☐ RETIRED

OCCUPATION: _____

PRIMARY CARE PROVIDER:

PHYSICIAN FIRST/LAST NAME:_____

PHONE:_____ FAX: :_____

ADDRESS:_____

PHARMACY INFORMATION:

NAME: _____ PHARMACY PHONE:_____

ADDRESS: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY:

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

TO WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured / Guardian: _____ Date: _____

INSURANCE COMPANY: _____SUBSCRBER ID#_____
INSURED FIRST/LAST NAME:_____ DOB:_____
RELATIONSHIP: _____SSN#:_____
ADDRESS: _____
PHONE: _____ GROUP #:_____ CO-PAY: _____
INSURED EMPLOYED BY? _____ BUSINESS PHONE: _____
BUSINESS ADDRESS: _____

SECONDARY INSURANCE: _____SUBSCRBER ID#_____
INSURED FIRST/LAST NAME:_____ DOB:_____
RELATIONSHIP: _____SSN#:_____
PHONE: _____ GROUP #:_____ CO-PAY: _____

Authorization to release or use information for treatment, payment, or health care operations.
I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Dr. Bregman / Bregman Foot-Ankle & Nerve Center to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this consent form. We reserve the right to change the terms of this Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such restrictions requested; however, if we do agree to your requested restriction(s), such restrictions are then biding on the Practice.

I agree and consent to Bregman Foot-Ankle & Nerve Center releasing information to me in the following manner:

* **PLEASE INITIAL** *

VIA MAIL	☐ OK TO MAIL TO HOME ADDRESS	
VIA HOME TELEPHONE / VIA CELL PHONE	☐ OK TO LEAVE DETAILED MESSAGE ☐ OK TO TEXT DETAILED MESSAGE	
VIA EMAIL	☐ OK TO LEAVE DETAILED MESSAGE	

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured / Guardian: _____ Date: _____

NAME: _____ DOB: _____ INSURANCE: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ PREGNANT: _____NURSING: _____

TOBACCO USE: ☐ YES ☐ NO PACKS PER DAY: _____ YEARS OF TOBACCO USE: _____

FORMER SMOKER: ☐ YES ☐ NO WHEN DID YOU QUIT SMOKING: _____

ALCOHOL USE: ☐ YES ☐ NO ☐ OCCASIONAL ☐ SOCIAL ☐ FREQUENT- DRINKS PER DAY _____

MARIJUANA / CBD USE: ☐ YES ☐ NO HISTORY OF ILLICIT DRUG USE: ☐ YES ☐ NO

HISTORY OF FALLS: _____ ADVANCED DIRECTIVE? ☐ YES ☐ NO

RECENT HOSPITALIZATION: _____

DIABETIC: ☐ YES ☐ NO **IF YES, RECENT A1C:** _____

☐ No Known Drug Allergies

ALLERGIES **&** REACTION:_____

MEDICATION	DOSE / FREQUENCY	WHAT MEDICAL CONDITION IS THIS PRESCRIBED FOR?

PATIENT Medical History:

☐ ARTHRITIS ☐ BUNION ☐ BLOOD DISORDERS ☐ CANCER ☐ DIABETES ☐ GOUT ☐ FLAT FEET ☐ HAMMERTOES
☐ HEART DISEASE ☐ HYPERTENSION ☐ HIGH CHOLESTEROL ☐ KIDNEY DISEASE ☐ LIVER DISEASE ☐ LUNG DISEASE
☐ OBESITY ☐ OSTEOPOROSIS ☐ STROKE

Other: _____

FAMILY Medical History:

☐ ARTHRITIS ☐ BUNION ☐ BLOOD DISORDERS ☐ CANCER ☐ DIABETES ☐ GOUT ☐ FLAT FEET ☐ HAMMERTOES
☐ HEART DISEASE ☐ HYPERTENSION ☐ HIGH CHOLESTEROL ☐ KIDNEY DISEASE ☐ LIVER DISEASE ☐ LUNG DISEASE
☐ OBESITY ☐ OSTEOPOROSIS ☐ STROKE

Other: _____

Please list your Surgical History (Month/Year): ☐ NO HISTORY OF SURGERY

_____

_____

_____

_____

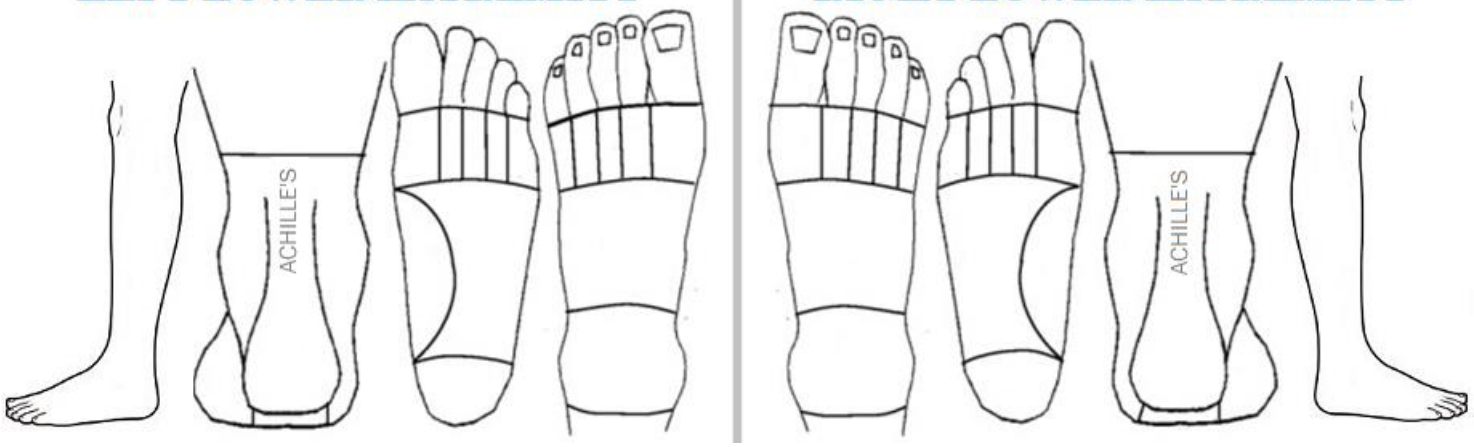
Describe your condition: _____

_____

_____

_____

LEFT LOWER EXTREMITY **RIGHT LOWER EXTREMITY**



◇CONSTANT ◇INTERMITTENT ◇ACHING ◇BURNING ◇CRAMPING ◇DEEP ◇DULL ◇ELECTRICAL ◇HOT ◇ITCHING ◇NAGGING ◇NUMBNESS ◇PRICKLING ◇PIERCING ◇PRESSURE ◇RADIATING ◇REDNESS ◇SENSITIVE ◇SHOCKING ◇SHOOTING SHARP ◇SORE ◇STABBING ◇SQUEEZING ◇SWELLING ◇THROBBING ◇TINGLING ◇TIGHTNESS ◇WORSE WITH ACTIVITY ◇PAIN FIRST THING IN THE MORNING WAKING UP ◇PAIN AT NIGHT DURING HOUR OF SLEEP

OTHER: _____

DURATION OF SYMPTOMS: _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

PLEASE SELECT YOUR PAIN LEVEL

☐ **0** – No pain

MILD PAIN – ***nagging, annoying, but doesn't really interfere with daily living activities.***

☐ **1** – Mild pain, barely noticeable but you are aware of the pain. Most of the time you don't think about it.

☐ **2** – Minor pain. Annoying and may have occasional strong pangs/twinges.

☐ **3** – Uncomfortable pain, noticeable and distracting, however, you can get used to it and adjust.

MODERATE PAIN – ***interferes significantly with daily living activities.***

☐ **4** – Moderate pain. If you are deeply involved in an activity, it can be ignored for a period but is still distracting.

☐ **5** – Distracting pain, it cannot be ignored for more than a few minutes, but with effort you still can manage to work or participate in some activities.

☐ **6** – Distressing pain interferes with normal daily activities. Difficulty concentrating/thinking/problem solving.

HIGH PAIN – ***unable to perform daily living activities.***

☐ **7** – High pain, overwhelming pain that dominates your senses and significantly limits your ability to perform normal daily activities or maintain social relationships. Interferes with sleep. Thinking about pain 80%-90% of your day. Cannot move.

☐ **8** – Severe/intense pain. Physical activity is severely limited. Conversing requires great effort. Personality change. Nausea and dizziness may occur. **(Childbirth is often cited as this level)**

SEVERE PAIN – ***disabling; so painful you need to go to the Emergency Room***

☐ **9** – Excruciating pain. Crying out and/or moaning uncontrollably. Unable to talk. Unable to move. Incoherent groaning. So painful you need to go to the ER for pain treatment.

☐ **10** – Unspeakable pain. Bedridden/incapacitated and possibly delirious. Possible confusion. Unconsciousness. Pain makes you pass out. Very few people will ever experience this level of pain.

PREVIOUS TREATMENT: ☐ ICING ☐ OTC MEDICATION ☐ STEROID INJECTIONS ☐ SHOE INSERTS / BRACE

☐ PHYSICAL THERAPY ☐ SURGERY ☐ OTHER: _____

Which treatment was MOST helpful? _____

BREGMAN
FOOT-ANKLE & NERVE CENTER

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents, children or employers to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Bregman Foot-Ankle and Nerve Center to release my records and any information requested to the following individuals.

1. _____ Relation to Patient :_____

2. _____ Relation to Patient :_____

3. _____ Relation to Patient :_____

4. _____ Relation to Patient :_____

Please check all that apply:

☐ Information regarding office appointments/visits or referrals

☐ Information regarding all test results

☐ Information regarding billing, financial information, or insurance information

☐ Information regarding procedures performed or will be performed by Dr. Bregman

Patient Signature : _____ Date : _____

Patient Name : _____