



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 for 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 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 I 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.

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 will be 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. Charge for processing FMLA forms or Short-Term Disability forms (\$50-fifty dollars each new request), 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.

PLEASE UNDERSTAND THAT IT IS ULTIMATELY THE PATIENT’S RESPONSIBILITY TO KNOW HIS OR 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 be advised that 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:

<input type="checkbox"/> ALL RECORDS	<input type="checkbox"/> RADIOLOGY REPORT	<input type="checkbox"/> LAB REPORT	<input type="checkbox"/> EMG/NCV REPORT
<input type="checkbox"/> OPERATIVE REPORT	<input type="checkbox"/> CLINICAL NOTES	<input type="checkbox"/> DATES:	
<input type="checkbox"/> 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

1st Request: _____ 2nd Request: _____ 3rd Request: _____

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

SECONDARY INSURANCE: _____ **SUBSCRIBER 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 in order 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 requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

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

*** PLEASE INITIAL ***

VIA MAIL	<input type="checkbox"/> OK TO MAIL TO HOME ADDRESS <input type="checkbox"/> OK TO MAIL TO WORK ADDRESS	
VIA HOME TELEPHONE / VIA CELL PHONE	<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGE <input type="checkbox"/> LEAVE CALL BACK NUMBER ONLY <input type="checkbox"/> OK TO TEXT DETAILED MESSAGE	
VIA WORK TELEPHONE	<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGE <input type="checkbox"/> LEAVE CALL BACK NUMBER ONLY	
VIA EMAIL	<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGE <input type="checkbox"/> LEAVE CALL BACK NUMBER ONLY	
VIA FAX	<input type="checkbox"/> OK TO FAX TO NUMBER BELOW:	

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

Signature of Insured / Guardian: _____ **Date:** _____

NAME: _____ DOB: _____ INS: _____

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

REASON FOR RECENT HOSPITALIZATION: _____

NO KNOWN DRUG ALLERGIES

ALLERGIES & REACTION: _____

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

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

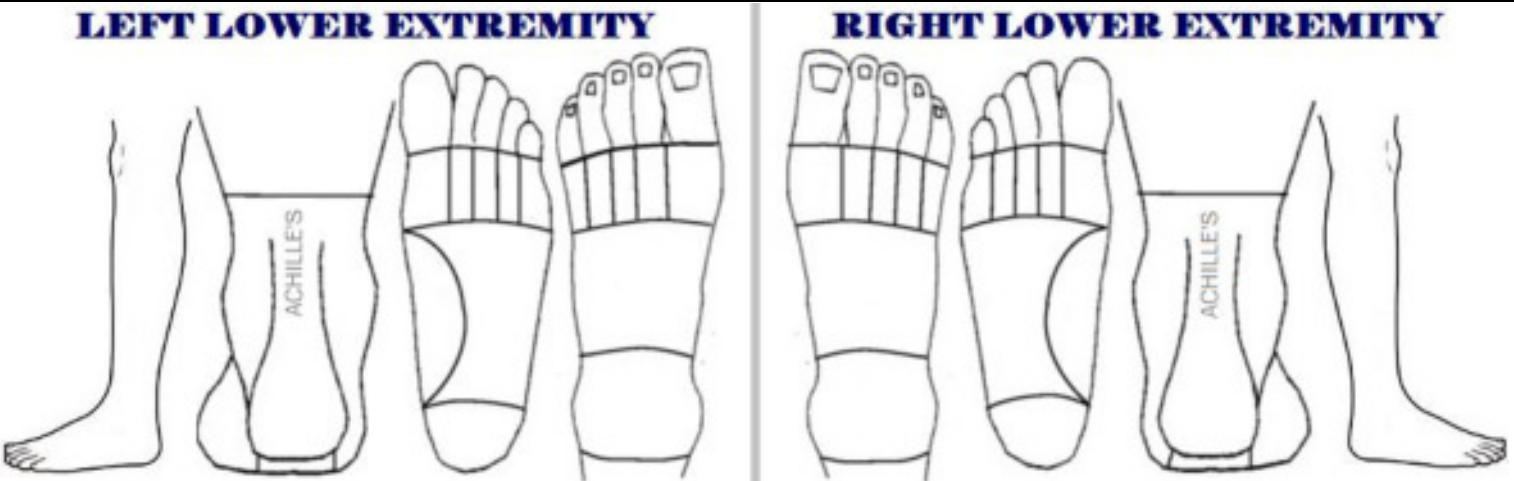
OTHER: _____

PLEASE LIST YOUR SURGICAL HISTORY (MONTH / YEAR):

NO HISTORY OF SURGERY

VITALS: TEMP: _____ HR: _____ BP: _____ O2 SAT: _____

Describe your condition: _____



- ◇ CONSTANT ◇ INTERMITTENT ◇ ACHING ◇ BURNING ◇ CRAMPING ◇ DEEP ◇ DULL ◇ ELECTRICAL ◇ 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 do not think about it.
- 2 – Minor pain. Annoying and may have occasional strong spasms/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, and or 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 Emergency Room for pain treatment right NOW.
- 10 – Unspeakable pain. Bedridden/incapacitated and possibly delirious. Possible confusion. Unconsciousness. Pain makes you pass out. You ARE in the Emergency Room. Very few people will ever experience this level of pain.

PREVIOUS TREATMENT: ICING OTC MEDICATION STEROID INJECTIONS SHOE INSERTS / AFO BRACE
 PHYSICAL THERAPY SURGERY OTHER: _____

Which treatment was helpful? _____



MEDICAL LIEN

Attorney's Name: _____		
Address: _____		
Phone: _____	Fax: _____	
Patient's Name: _____ DOB: _____		
Patient's Phone: _____	Date of Injury: _____	
Address: _____		
Claim Number: _____		

I do hereby authorize the above medical provider to furnish you, my attorney, with full report of his examination, diagnoses, treatment, prognosis, etc. of myself regarding the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing him for medical services rendered to me both by reason of this incident and by reason of another settlement, judgment or verdict as may be necessary to adequately protect said provider. I hereby further give a lien on my case to said provider against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries or which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said provider for all the medical bills submitted by him for services rendered to me and that this agreement is made solely for said provider's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

I agree that if I change attorneys, that this agreement will remain enforce and effect and that I will notify and subsequent attorney of this lien and notify you the name, address, telephone number of my new attorney. I agree to waive the statute of limitation for the services you provide to me pursuant to the Code of Civil Procedure. Should any party fail to abide by the terms of this agreement and suit be filed to enforce any terms or conditions, the prevailing party shall be entitled to reasonable attorney fees.

Patient's Signature	Print Name	Date
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Attorney's Signature	Print Name	Date
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PATIENT REQUEST FOR MEDICAL RECORDS

PATIENT NAME: _____

PATIENT DOB: _____

ADDRESS: _____

PATIENT PHONE: _____

PLEASE PROVIDE A PHOTO ID WHEN REQUESTING RECORDS

◇ 60 CENT PER PAGE PRINTING FEE ◇ NUMBER OF PAGES: _____ ◇ TOTAL PRINT FEE: _____

Purpose for request of Medical Records:

Continuity of care
 Change of Insurance/Provider
 Referral
 Other: _____

Specific description of the information to be released:

<input type="checkbox"/> ALL RECORDS	<input type="checkbox"/> RADIOLOGY REPORT	<input type="checkbox"/> LAB REPORT	<input type="checkbox"/> EMG/NCV REPORT
<input type="checkbox"/> OPERATIVE REPORT	<input type="checkbox"/> CLINICAL NOTES	<input type="checkbox"/> DATES:	
<input type="checkbox"/> OTHER:			

PLEASE ALLOW UP TO 5-14 BUSINESS DAYS

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

RELATIONSHIP

PRINT NAME OF PATIENT OR LEGAL REPRESENTATIVE

DATE



BREGMAN FOOT-ANKLE & NERVE CENTER

7150 W SUNSET RD SUITE #110 LAS VEGAS, NV 89113

Phone: #702-703-2526 ♦ FAX: #800-638-8056

PLEASE FEEL FREE TO TEXT US: #702-553-3739

Office Contact Information

DrBregman@BregmanFANCE.com

Reception@BregmanFANCE.com

Admin@BregmanFANCE.com

MA@BregmanFANCE.com