REGISTRATION INFORMATION

PATIENT INFORMATION

First name:_____ MI:_____ Last name:_____

Mailing address:_____ City:_____ State:_____ Zip_____

Sex at birth Male:___ Female:____ Date of Birth:_____ Age:_____ Social security:_____

Employer:_____ Email: _____

Work Phone:_____ Cell Phone:_____ Home Phone:_____

Primary Care Provider/ Facility:_____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "self" and move down to "I give".
Patient's relationship to responsible party: Self:___ Spouse:_____ Dependent:_____

First name: _____ _____ MI:_____ Last name:_____

Mailing address: _____ City:_____ State:_____ Zip: _____

Sex at Birth Male:____ Female:____ Date of Birth: _____Age:_____ Social Security:_____

Employer: _____ Employer Address:_____

Work Phone: _____ Cell Phone:_____ Home Phone: _____

I give Mission Foot and Ankle permission to release my medical information to the following:

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

I give MISSION Foot and Ankle, PLLC permission to call/text for appointment reminders. _____YES _____NO

ASSIGNMENT AND RELEASE

I hereby assign, transfer, and set over to _____all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any of my medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. **I understand that I am financially responsible for all charges whether or not they are covered by insurance.**

Patient's Signature: _____ Date: _____

MISSION Foot and Ankle, PLLC. Financial Policy

Thank you for choosing MISSION Foot and Ankle, PLLC as your lower extremity specialty health care provider. We are committed to building a successful physician- patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Do not hesitate to ask any questions regarding our fees, policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with the office manager. We accept cash and debit/credit card only.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we are out of network with your insurance company and your insurance pays your directly, you are responsible for payment and agree to forward the payment to us immediately.

Workers Compensation and Automobile Accidents

In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance company prior to your visit. MISSION Foot & Ankle, PLLC must receive authorization prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Missed Appointments

We require 24- hour notice cancellation. Appointments missed and are not previously canceled may be charged a fee of $25.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy

It is our policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make pay arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections cost including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

I have read the above financial policy and understand my financial responsibility to my health care provider.

Patient Signature Date Witness

MISSION Foot and Ankle, PLLC

Privacy Contract. If you have any questions about this policy or your rights contact the Privacy Officer, Peggy Brewington at 910-280-9970

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond MISSION Foot and Ankle. This includes for :

Treatment. With your permission we may use or disclose personal information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside MISSION Foot and Ankle that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This may include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.

Information Disclosed Without Your Consent. Under State and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health- related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable disease or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral director for the purposes of carrying out their duties.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested, with the Department of Health and Human Resources to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS

You have the right following rights under State and federal law:

Copy of Record. You are entitled to inspect the personal health record MISSION Foot and Ankle has generated about you. We may charge you a reasonable fee of $25 for copying and mailing your record.

Release of Records. You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action had been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the personal health information. This request must be in writing. MISSION Foot and Ankle is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Program Director who will consult with the staff involved in your care to determine if the request can be granted.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information that you are providing is correct. Due to agency policy, we are not able to provide information by email.

Accounting for Disclosures. You may request an listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our Privacy Officer in writing or in office. You may also complain to the Secretary of Health and Human Services if you believe MISSION Foot and Ankle has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. MISSION Foot and Ankle reserves the right to change its Privacy Policy based on the needs of MISSION Foot and Ankle and changes in state and federal law.

MISSION Foot and Ankle, PLLC

USE and DISCLOSURE OF PROTECTED HEALTH INFORMATION: EFFECTIVE APRIL 01, 2010

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.

We are required by law to maintain the privacy of your health and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As our client, facts about you must be used and disclosed to other parties for treatment, payment and health care operations. This use and disclosure requires your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records
- Diseases spread person to person: i.e. Human Immune Deficiency (HIV) and Acquired Immune Deficiency Syndrome (AIDS)
- Drug and or alcohol abuse
- Psychiatric diagnosis and treatment records
- Laboratory test results
- Medical history
- Treatment progress
- Data from the OASIS data set (home health)
- Current medication list and detailed prescription history
- Any other related facts

We may release the above to:

- Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment
- Any person from a program or an insurance company, who performs billing, quality and risk management task, such as insurance auditors and state Risk Management
- Any hospital, nursing home, or other health care facility where you may have testing done or to which you may be admitted
- Any assisted living or personal care facility where you live
- Any doctor providing you treatment
- Family members and or other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc
- State and or Federal agencies acting on behalf of programs, Medicare and or Medicaid, including state surveyors or audits for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc
- Other health care providers to start treatment

We may contact you to:

- Provide appointment reminders or news about other health programs we provide

We are allowed to use and disclose facts about you without consent in the following situations:

- In emergency treatment situations, if we try to obtain consent as soon as possible after treatment
- Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation
- Where we are required by law to provide treatment and we are unable to obtain consent
- Where the use and disclosure is required by law
- For certain public health activities, such as reporting births, deaths, injuries, diseases, etc
- Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect or domestic violence reports
- Certain legal administrative proceedings
- Certain law enforcement purposes
- To coroners, medical examiners and funeral directors in certain situations (home health, hospice, etc)
- For organ, eye or tissue donation purposes (home health, hospice, etc)
- For certain research purposes
- To avoid a serious threat to health and safety
- For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situations
- For Workers' Compensation purposes

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

- The use of a directory of people served by us (clinic schedules, patient schedules)
- To a family member, friend or other person you choose, who may assist in your care or payment for care
- Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

You have the right, subject to certain conditions to:

- Request restrictions on certain uses and disclosures of facts about you by filing out our Request form. However, we are not required to agree to the requested restrictions.
- Receive confidential communication of protected health data by giving us another address or means of receiving health data.
- Inspect and copy protected health data by filing out our Request form
- Amend protected health data by filing out our form
- Receive a list of disclosures made of your protected health data by filing out our Request form.
- Obtain a paper copy of this notice upon request, if you agree to receive this notice by email, fax, or website.

COMPLAINTS

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be ne retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident.

For details about filing a complaint with us, contact:
HIPAA Compliance Officer Peggy Brewington 910-280-9970
More details can be found at https://public health.nc.gov/privacy.html

ACKNOWLEDGMENT

I have read this Notice or have had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I do not understand.

Patient Signature Date

For Staff Use Only
Good faith efforts have been made to obtain acknowledgment of this disclosure.

MISSION Foot and Ankle Staff Signature Date