

Philip Wrotslawsky, DPM, A Professional Corporation
Patient Registration Form

How did you hear about our office? _____
Primary Care Physician? _____

Date: _____

Patient: _____ Date of Birth: _____ Age: _____ Male _____ Female _____

Address: _____ City/State: _____ Zip Code: _____

Home Ph#: _____ Cell Ph#: _____ Work Ph#: _____ e-mail: _____

Soc. Sec.#: _____ Drivers Lic.#: _____ Full-Time Student: _____ Part-Time Student _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Your Occupation: _____ Employed By: _____ Phone #: _____

Employer's Address: _____ City/State/Zip: _____

Family Physician: Name _____ Phone # _____

Address: _____

Referred by: _____ Address: _____

Spouse's/Parent Name: _____ SS#: _____ Employer: _____

Emergency Contact: _____ Phone#: _____

IF PERSON RESPONSIBLE FOR PAYMENT IS OTHER THAN PATIENT, PLEASE COMPLETE THE FOLLOWING

Person Responsible for Payment: _____ Date of Birth: _____ Soc Sec#: _____

Relationship to patient: _____ Occupation: _____ Work Phone: _____

Employed by: _____ Address: _____

DATE OF ACCIDENT/INJURY: _____ Auto Accident _____ Work Related Injury _____

PRIMARY INSURANCE:

Name of Company: _____ Phone: _____

Billing Address: _____ City/State/Zip: _____

POLICY HOLDER NAME: _____ **SS#:** _____ **Relationship to Patient:** _____

Group Name: _____ **Policy #:** _____ **Group #:** _____

SECONDARY INSURANCE:

Name of Company: _____ Phone: _____

Billing Address: _____ City/State/Zip: _____

POLICY HOLDER NAME: _____ **SS#:** _____

Relationship to Patient: _____ **Group Name:** _____

Policy #: _____ **Group #:** _____

*****ATTENTION: Please sign all forms*****

If you do not sign the responsibility for filing insurance and payment for bills will be YOURS.

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). Should the account be referred to any attorney for collection, the undersigned shall pay actual attorney's fees and collection expenses. If I am uninsured, I understand that I am fully responsible for ALL charges.

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: _____

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or it's intermediaries or carriers, or to the billing agent of Philip Wrotslavsky, DPM, A Professional Corporation any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

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.
Thank You*

Philip Wrotslavsky, DPM, A Professional Corporation
FINANCIAL POLICY AND PATIENT AGREEMENT

The following is the Financial Policy for Philip Wrotslavsky, DPM, A Professional Corporation. We are committed to giving you the best care possible: we expect in return that you have the same commitment to your medical and financial responsibility to us.

CUSTOMER SERVICE: 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. We accept cash, checks, or credit cards (Visa, MasterCard) as payment. **There will be a \$20.00 service charge on any returned checks.**

APPOINTMENTS: Even if you are an established patient with us, it is advisable to arrive 5-10 minutes before your scheduled appointment time for updating your record and/or paying your co-payment. We understand that emergencies arise necessitating changing your appointment date and/or time. If you fail to cancel or reschedule, we will excuse your first failed appointment: however **any subsequent failed appointments will be charged to you (\$25.00 each).**

WORKERS COMP: We need the name of your Comp. Carrier, their address, your claim number and the name and phone number of any contact person. If that information is unavailable on **your** first visit **you are responsible for the bill until that information has been given to us.**

SELF-PAY: Payments must be rendered at time of service.

MOTOR VEHICLE ACCIDENT: **We have 30 days to file our claim with your insurance carrier, and must have that billing information.**

PPO/HMO: If we have agreement with your insurance carrier, we will receive direct payment for covered services. Co-payments are due at time of service. Deductible and coinsurance amounts applied to the claim will be due from you at time of service. Services not covered or deemed not medically necessary by your plan will be billed to you. Referrals are the patient's responsibility. If a referral is not in place, you will be responsible for payment or will be rescheduled.

INDEMNITY-TYPE INSURANCE: Your insurance may or may not agree with the UCR (usual, customary and reasonable) charges for our local area. Your benefit plan may not cover all services or may even deny payment for services. Should there remain a balance on your **account** for any reason after your insurance has been processed, you will be responsible for payment.

LIENS: We accept liens although with the approval of the Manager and/or Doctor. A deposit of \$100.00 is required and should be reimbursed to you from your insurance company at the end.

BILLING: We will fine your primary and supplemental insurance for you if you provide us with the billing information and a copy of your insurance cards. Our statements go out the end of the month. If you have insurance, we will allow 60 days for them to respond to the bill. If they have not responded in that time frame, we ask that you begin making payments on your account while you resolve the billing problems with your insurance company.

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 \$15.00.

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".*

PATIENT SIGNATURE

DATE

WITNESS

DATE

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to a 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 in 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 TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

BY: _____	Physician's or Duly Authorized Representative	(Date)	BY: _____	Patient's Signature	(Date)
	Philip Wroslawsky, DPM, A Professional Corporation				
	Philip Wroslawsky, DPM, 15525 Pomerado Rd., Ste. E-6, Poway, Ca. 92064				
	Print or Stamp Name			Print Patient's Name	
	Medical Group or Association Name				

BY: _____	Signature of Translator (If applicable)	(Date)	BY: _____	Patient's Representative's Signature	(Date)
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Print Name of Translator

Print Name and Relationship to Patient

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Philip Wrotslavsky, DPM, A Professional Corporation
15525 Pomerado Road, Suite E-6
Poway, California 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, 2005 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.**