Welcome To Our Office

Patient registration

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for reminder calls and other electronically generated messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number : ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female		Family Physician or Pediatrician:
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:		First Name:
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** o ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Chinese ☐ Indian (including Hindi & Tamil) ☐ Japanese ☐ Sign Language ☐ Spanish ☐ Russian ☐ Tagalog ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I authorize Dr. Anthony V. Borgia DPM PLLC dba Silver State Foot & Ankle Institute to perform examination or treatment needed to diagnose and/or treat my foot/ankle condition. I also authorize the taking of and usage of clinical photographs. It is understood that these photos may be used to further medical education and that my identity will not be revealed. I further understand that X-rays are the property of Silver State Foot & Ankle Institute. I understand that I, or the person responsible for paying my bills, is financially responsible for charges not covered by my insurance. All insurance plans are not the same and do not cover the same procedures. In the event my health care plan determines a service to "not be covered", I understand I am responsible for the complete charge.

I request that payment of authorized benefits be made to Silver State Foot & Ankle Institute for any services furnished to me by Silver State Foot & Ankle Institute. I authorize any holder of medical information about me to be released to my insurance company and its agents and any information needed to determine these benefits or these benefits payable to related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If item 13 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown.

All deductible, co-payments and applicable charges will be due at the time of service - NO EXCEPTIONS.

Please supply us with your valid insurance card and Government Issued identification so we may photocopy it for our file
(Services must be paid at the time of service if we don't participate with your insurance)

Signature of Responsible Party: _____ **Date:** _____

Printed Name of Responsible Party: _____

Patient Name_____ **Date** _____

Medical History (please Check)

CARDIOVASCULAR
- ☐ Heart attack
- ☐ Arrhythmia
- ☐ Pacemaker
- ☐ Bypass surgery
- ☐ High blood pressure
- ☐ Heat failure
- ☐ Chest pain
- ☐ Swelling of ankles
- ☐ Artificial valve
- ☐ Cramping in legs

ENDOCRINE
- ☐ Diabetes ☐ I ☐ II
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Osteoporosis
- ☐ Other_____

NERVOUS
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Headaches, migraine
- ☐ Numbness/tingling
- ☐ Alzheimer's Disease
- ☐ Paralysis

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Other_____

DIGESTIVE
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Ulcers
- ☐ Reflux

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Chronic Pain
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fracture(s)
- ☐ Back pain

URINARY
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Burning

SKIN
- ☐ Rash/hives
- ☐ Open wound/ulcer
- ☐ Blisters
- ☐ Dry/scaly
- ☐ Change in color

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic cough

BLOOD
- ☐ Difficult clotting
- ☐ Bruise easily
- ☐ Anemia

HEENT
- ☐ Hearing Impairment
- ☐ Visual Impairment
- ☐ Throat Conditions
- ☐ Ringing in the Ears
- ☐ Balance Disturbance
- ☐ Sinus/Allergy

OTHER
- ☐ Cancer
- ☐ HIV

Do you drink alcohol? ☐ Yes ☐ No If so, how much _____

Do you smoke? ☐ Yes ☐ No If so, how much _____

Any other diseases or injuries that we should know about_____

_____

List any member of your family (Mother, Father, Brothers, Sisters, Grandparents) who has had or now has the conditions listed below: (Please indicate who, if they died from this condition, and age at death)

Asthma/Respiratory Diseases_____ Diabetes_____

High Blood Pressure_____ Strokes_____

Severe Arthritis_____ Cancer_____

Heart Disease_____ Gout _____

Patient Name_____ **Date** _____

To insure a complete medical history, please complete ALL sections of this form

What is you present foot or ankle problem? _____

_____

_____

If female, could you possibly be pregnant? ☐Yes ☐No

Where is your problem located? ☐Toe ☐Ball of foot ☐Midfoot/Arch ☐Heel ☐Ankle ☐Leg

What type of pain are you experiencing? ☐Aching ☐Throbbing ☐Burning ☐Stabbing ☐Sharp ☐Dull

☐Numbness ☐Stiffness ☐Cramping ☐Other _____

Radiation of pain?☐No Radiation ☐Heel ☐Achilles Tendon ☐Arch ☐Forefoot ☐Toes ☐Calf ☐Sheen ☐Knee

How would you rate your pain? ☐Mild ☐Moderate ☐Severe

What is the duration of symptoms? ☐Days _____☐Weeks_____ ☐Months_____ ☐Years_____

Pain better with?☐ Nothing helps ☐ Aspirin☐ Compression ☐Heat ☐Ice ☐Rest ☐Stratching ☐Immobilization of Ankle

Pain worse with? ☐No aggravation factors ☐Weight-bearing☐ Compressions ☐Other_____

What is the frequency of pain? ☐Intermittent ☐Constant ☐After Rest ☐Other _____

Did symptoms occur as a result of an injury? ☐ No ☐Running ☐Jumping ☐Climbing ☐A fall ☐Stepping in a hole

☐ Has any treatment been rendered by yourself or a physician? (i.e. medication, shoe gear, ice, arch supports, insoles, injection)_____

Does your occupation require prolonged standing or walking? _____

Which best describes your activity level? ☐Inactive ☐Moderately ☐Active ☐Very Active

Did you have any foot or ankle problems as a child? _____

Medications (or provide list that may be photocopied):

(Example: Feldene, 20 mg, I x daily):

_____

_____

_____

_____

_____

_____

Have you had or do you now have allergies & type of reaction:

☐Penicillin_____ ☐Local Anesthesia _____ ☐Sulfa Drugs _____

☐Tapes or band aids_____ ☐Iodine _____ ☐Silver _____

☐Codeine _____ ☐Aspirin_____ ☐Foods _____

☐None ☐ Other _____

Please list any surgeries and/or hospitalization that you have had: (Example: Tonsillectomy, 1984, Dr. Smith)

_____

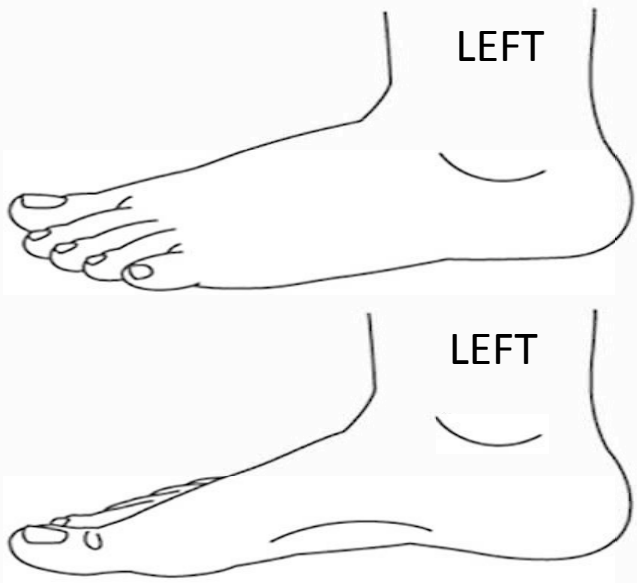
_____

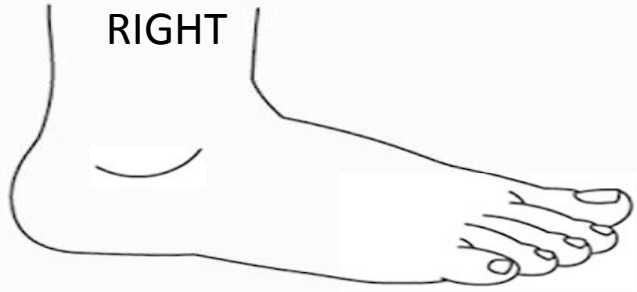
_____

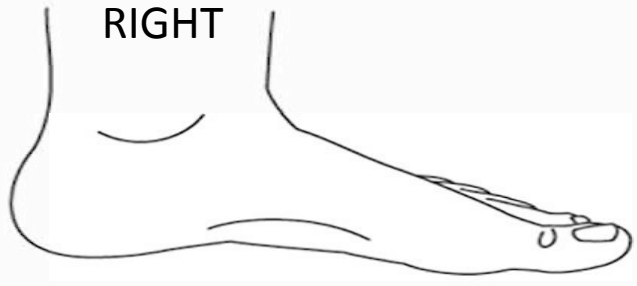
_____

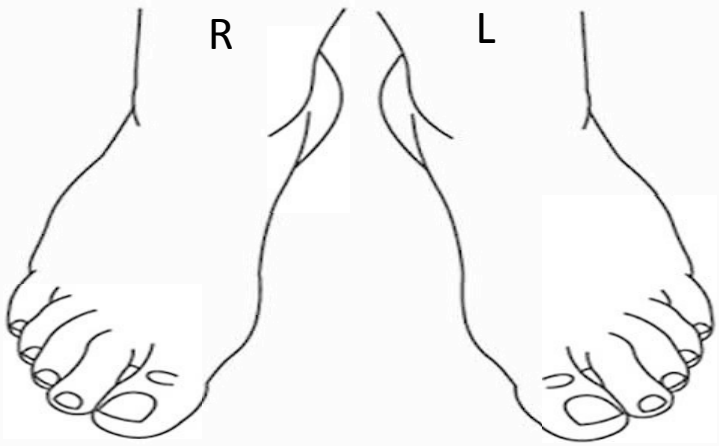
Patient Name_____Date _____

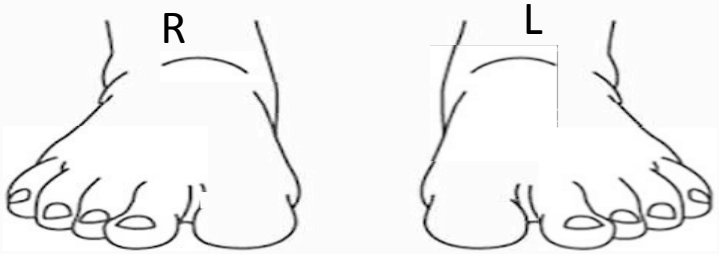
Please Indicate all areas of concern to help us learn more about your condition so that we can better assist your needs.

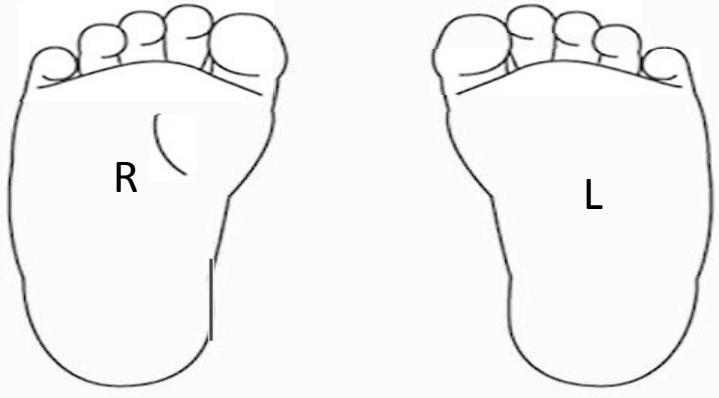












What **tests** have you had done?

☐X-Rays Date:_____ ☐Cat scan Date:_____ ☐MRI Date: _____

Where? _____

Patient consent for use and disclosure of protected health information.

With my consent, Dr. Borgia may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Operations (TPO). Please refer to Dr. Borgia Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Dr. Borgia reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Silver State Foot & Ankle Institute
9260 W Sunset Rd Suite 201
Las Vegas, NV 89148

With my consent, Dr. Borgia may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among other.

With my consent, Dr. Borgia may mail to my home or other designated location any items that assist the practice in carrying out (TPO), such as appointments reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Dr. Borgia may e-mail to my home or other designated location any items that assist the practice in carrying out (TPO), such as appointment reminders cards and patient statements. I have the right to request that Dr. Borgia restrict how it uses or disclose my (PHI) to carry to (TPO).

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dr. Borgia use and disclosure of my (PHI) to carry out (TPO). I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Borgia may decline to provide treatment to me.

Patient
Legal Guardian Signature: _____

Print Patient Name: _____

Date: _____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Anthony V Borgia DPM

Financial Responsibility

I have requested professional services from Anthony V Borgia DPM ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and(3) allow a photocopy of my signature to be used to process insurance claims I understand that any information disclosed pursuant to this authorization may be disclosed by the recipient pursuant to my providers Notice of Privacy disclosure and may not be protected by the federal privacy regulation. I understand that I have a right to revoke this authorization at any time by providing written notice to my Provider and my health benefit plan (or its administrator) via electronic mail, U.S. mail or facsimile. I further understand that there are no exceptions to my rights to revoke this authorization. Therefore, this authorization will remain in force and effect for claims with date of service within **one year** of the signature date, or until revoked by me in writing, or until my healthcare claims are adjudicated to my provider's satisfaction**.**

ERISA Authorization and Limited Power of Attorney

I hereby designate, authorize, and convey to PROFESSIONAL BILLING LLC, Provider's Third-Party Billing Service for the claims assigned hereunder, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to sign any and all documents that require my signature, sent to or received from my health benefit plan (or its administrator) on my behalf, in the event that my health benefit plan (or its administrator) requires additional information; (2) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan and assigned hereunder to Provider; and (3) the right and ability to act as my Authorized Representative to pursue any such claim, right, or cause of action in connection with said insurance policy and/or benefit plan including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines;

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient signature Date

_____ _____

Policyholder/Insured Date

FINANCIAL POLICY

Thank you for choosing Anthony V. Borgia DPM, PLLC dba Silver State Foot & Ankle Institute as your healthcare provider. We are committed to timely, successful and cost efficient treatment of your health care needs. In order for us to maintain this high standard of health care, it is necessary for us to strictly adhere to financial policies. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION:
Payment is due at the time of service. For your convenience, we accept cash, Visa, MasterCard, Discover credit and debit. All Co-pays and balances are due and payable at the time of service. Any Co-pays you have with your insurance is your responsibility.

INSURANCE:
As a courtesy to our patients, we will bill all of your insurances. In order to do so, we must have updated and accurate insurance information. Please be aware that your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits. Your account with this office is your responsibility whether or not your insurance company pays. If your insurance company has not paid your account in full within 90 days, your account will become a CASH account with the balance due and payable immediately and prior to your next visit.

MINOR PATIENTS:
The legal guardian of a minor patient is responsible for full payment of the account.

NO CALL/NO SHOW:
There will be a $35.00 fee for every one who does not call 24 hrs in advance to cancel their appointment.

UNEMANCIPATED MINOR:
Under the Privacy Rule; if the minor has the authority under state law to consent to the healthcare provided and does consent to the care and no other consent is required by law, then the minor alone controls their PHI. The parent or guardian may not have access to the minor's PHI or authorize its disclosure with out the patients consent. This is true even if the parent or guardian may also legally consent to treatment and does in fact give consent.

COLLECTION POLICY:
I agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event, my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection legal fees that may be added to my account. If referred to a collection service, I understand I will be discharged as a patient from Dr. Anthony Borgia.

RETURNED CHECKS:
There will be a $30.00 fee for all returned checks. If a check is returned, you will be expected to pay by cash, credit card, or money order all subsequent services.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Our strict adherence to this policy services to enhance our provider/patient relationships.

I have read, understand, and agree to this Financial Policy.

Patient
Legal Guardian Signature: _____

Print Patient Name: _____

Date: _____

Silver State Foot & Ankle Institute
9260 W Sunset Rd. Suite# 201
Las Vegas, NV 89148
Tel:(702)947-2005 Fax(702)947-4923

To whom it may concern:

Patients hereby acknowledge that it is their responsibility to check with their insurance companies regarding all covered benefits. All patients seeing the Doctor will need to make sure that claims will be processed in network and not out of network.
Out of network benefits will result in patient responsibility for payment due to insurance determination. This will result in a higher out of pocket expense for you, the patient.
Patient will be responsible for all balances occurred.

Authorized Signature:_____Date: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Records to Silver State Foot & Ankle Institute

I,_____(Date of Birth)_____hereby authorize the release of my records to Silver State Foot & Ankle Institute. Please fax records to (702)964-1416.

Records to Silver State Foot & Ankle Institute

I,_____(Date of Birth)_____hereby authorize the release of my records from Silver State Foot & Ankle Institute to the following person or facility:

Silver State Foot & Ankle Institute
9260 W Sunset Rd. Suite# 201
Las Vegas, NV 89148

This request and authorization applies to:

❑ Healthcare information relating to the following treatment, condition, or dates:
_____

❑ All healthcare information

❑ Other: _____

☐ **Yes** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above

☐ **No** I don't authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above

Patient
Legal Guardian Signature:_____**Date:**_____

I understand that:

- If I refuse to sign this authorization, my refusal may affect my ability to obtain treatment.
- I may obtain a copy of the health information that I am being asked to allow the use or disclosure for a free of $0.60 per page. Mail and pick-up options require pre-payment
- I may revoke this authorization at anytime in writing, signed by me only and delivered to: Silver State Foot and Ankle Institute, Medical Records Department, 9260 W Sunset Rd. Suite 160, Las Vegas, Nevada 89148.
- I have a right to receive a copy of this authorization for a fee of $0.60 per page.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA)