Maryland Foot & Ankle Restoration, LLC
Belcrest Surgery Center, LLC

8903 Shady Grove Court
Gaithersburg, MD 20877
(301) 519-3668 (FOOT)

6505 Belcrest Road, Suite 1
Hyattsville, MD 20782
(301) 699-9297

PATIENT REGISTRATION

PATIENT NAME Last	First	Middle

BILLING AND INSURANCE INFORMATION- CHECK ONE ◯ PERSONAL INJURY◯WORKERS COMPENSATION◯AUTO INJURY

PRIMARY	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP NUMBER
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY #	SUBSCRIBER'S DOB
	SUBSCRIBER'S EMPLOYER	HOME PHONE	WORK PHONE
	EMPLOYER'S ADDRESS	WORK PHONE	EFFECTIVE DATE
SECONDARY	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP NUMBER
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY #	SUBSCRIBER'S DOB
	SUBSCRIBER'S EMPLOYER	HOME PHONE	WORK PHONE
	EMPLOYER'S ADDRESS	WORK PHONE	EFFECTIVE DATE

RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I hereby authorize Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC in Maryland to release medical information to my insurance carrier(s) for the sole purpose of obtaining payment for my medical care. I agree that a copy of this release may be used in place of the original.

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I am responsible for all co-payments, co-insurances, deductibles and non-covered charges, paid in accordance with the benefits of my current insurance policy. Payment must be paid at the time of service. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the billing office and make payment arrangements. It is further agreed that in the event I fail to pay upon demand, should my account be referred to a collection agency and or attorney, I accept full responsibility to pay all collection cost and interest of 1.5% per month not to exceed 18% per annum and reasonable court costs. I understand I am responsible for a $25 charge for a non-sufficient fund (returned check).

We are a participating Medicare provider. Medicare as well as secondary insurance (if any) will be billed for you. However, that does not mean all services are covered. Patients are responsible for paying their annual deductibles if it has not yet been met. You are also responsible for any copayments at your office visit. These are usually 20% of the allowed amount for an item or service.

Self -Pay: Payment in full is due at the time of service if you do not have health insurance.

Non-Covered Services: Please be aware that some of the services you receive may not be covered or considered reasonable or necessary by your insurance. You are responsible for payment of these services.

Please note we do have a $25 no show fee for our practice that will be charged to patient s without a 24 hour notification. Also, please note we do have a $250 no show fee for our facility Belcrest Surgery Center, LLC that will be charged to patients without a 48 hour prior notification.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC.

I understand that all Durable Medical Equipment (DME) and Retail items dispensed to me are non-refundable and cannot be returned unless there is a factory defect with the product: at which time Maryland Foot & Ankle Restoration, LLC in Maryland will replace the defective item with a new item.

_____ _____

Patient or Legal Guardian Signature Date

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RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I hereby authorize Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right I will provide in writing to my physician any of the individuals involved in my care to which I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original.

I am aware that I may request that this release of Medical information may be revoked at any time by providing the physician's office with a dated and signed letter.

I authorize Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC to request my RX (medication list) History from SureScripts.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The HIPPA educational pamphlet provides information about how Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

We reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail or in person.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you. By signing below, you acknowledge receipt of our HIPPA regulations.

With consent Dr. JohnyMotran, DPM and/or staff may discuss my protected health information, including course of treatment with the following individuals:

_____ _____

Name Relationship

_____ _____

Name Relationship

[ ] NO DESIGNEE

ACCURATE HISTORY

I understand that honest and complete answers to each question stated below are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or member of the office staff for assistance.

_____ _____

Patient or Legal Guardian Signature Date

NOTICE OF PRIVACY PRACTICE

I acknowledge that I have seen a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient or Legal Guardian Print Name Date

_____

Patient or Legal Guardian Signature