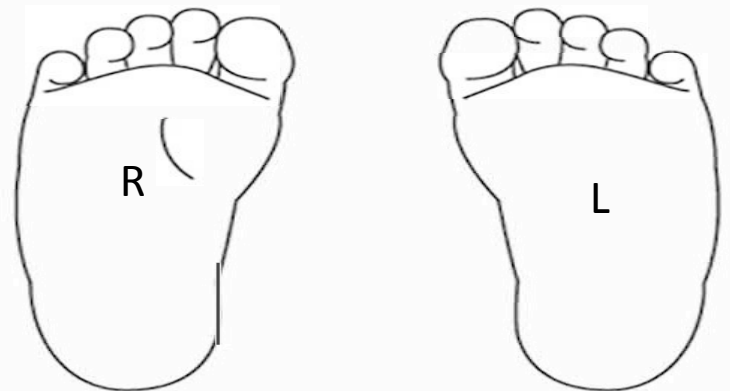
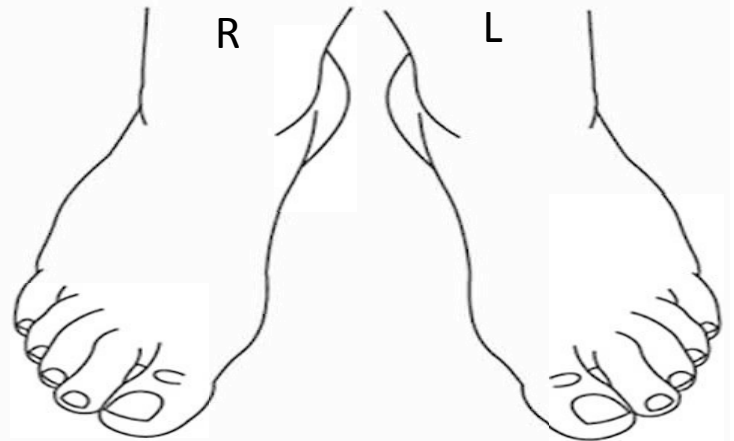
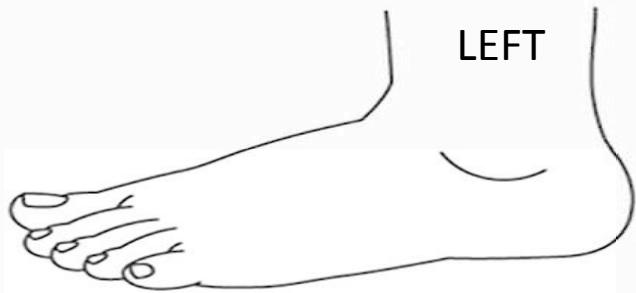


Patient Name _____ Date _____

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
2410 Fire Mesa St. Suite# 160
Las Vegas, NV 89128**

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 CHRIS DUFFY and/or ALLIANCE MED, 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
2410 Fire Mesa St. Suite# 160
Las Vegas, NV 89128
Tel:(702)947-2005 Fax(702)946-1416**

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
2410 Fire Mesa St. Suite# 160
Las Vegas, NV 89128**

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 fee 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, 2410 Fire Mesa St. Suite 160, Las Vegas, Nevada 89128.
- 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)