BIONICS ORTHOTICS & PROSTHETICS | Patient Registration

Patient first name: _____ Patient last name: _____

SSN: _____-____-_____ Date of birth: _____ Gender: _____

Main phone number: (_____) _____-_____ (Circle one) Home Cell Work

Alternate phone number: (_____) _____-_____ (Circle one) Home Cell Work

Home address: _____

_____ City: _____ State: _____ Zip: _____

Email address: _____

Preferred method of contact: Phone Email Mail

May we leave information about your device, diagnosis, or payment on voicemail? Yes No

May we send information about your device, diagnosis, or payment to you via email? Yes No

Emergency contact: _____ Relationship: _____

Phone number: (_____) _____-_____ (Circle one) Home Cell Work

Referred by: _____ Primary care physician: _____

Employed: Yes No Employer's name: _____

Work address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Is this work related? Yes No If yes, date of injury: _____

Work Comp Company: _____

You may provide a photocopy of your insurance card(s) in lieu of filling out the following:

Primary insurance

Name of insurance company: _____

Name of insured: _____ Relationship to insured: _____

Policy No.: _____ Group No.: _____

Secondary insurance

Name of insurance company: _____

Name of insured: _____ Relationship to insured: _____

Policy No.: _____ Group No.: _____

Assignment of Benefits/Release of Information

I hereby give lifetime authorization for payment of insurance benefits to be paid directly to practitioners of Bionics Orthotics and Prosthetics for services rendered. I hereby authorize practitioners to release all information necessary to process the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further understand that any overpayment of professional services to the practitioner will be reimbursed to me after the bill has been paid in full. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I further agree that a photo copy of this agreement shall be valid as the original.

Patient's signature: _____ Date: _____

BIONICS ORTHOTICS & PROSTHETICS | FINANCIAL POLICY

Thank you for choosing BIONICS ORTHOTICS & PROSTHETICS as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete and sign our Patient Information and Financial Policy form before seeing the practitioner. Please understand that payment for your bill is considered a part of your treatment.

Regarding your Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We may or may not choose to accept assignment of your insurance benefits. We cannot bill your insurance unless you give us your most current insurance information. **Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.** If the treatment is not a covered benefit under your policy, the balance will become due and payable by you at the time of delivery. **We accept cash, check, money order and Visa/MasterCard.**

Regarding insurance plans where we are not a participating provider: We will notify you in advance if we are not a participating provider. Please be aware that your insurance company may choose not to render payment if you do not have out-of-network benefits. We will notify you at the time of service if this option is available under your plan. If so, there is a chance that your out-of-pocket may be higher than that of a participating provider.

Usual and Customary Rates/Payment Recovery: Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. I also agree that, in the event I fail to fulfill my financial obligation, I will bear the cost of collection and/or court costs and reasonable legal fees should such action be required. I further agree that a photocopy of this agreement shall be valid as the original.

All copayments/deductibles are due at the time of delivery.

Bionics does NOT provide rental services.

A **$20.00** charge will be made to you, if you are a no call/no show. We highly recommend calling our office and canceling any appointment with us **24** hours advance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

BIONICS ORTHOTICS & PROSTHETICS | FINANCIAL POLICY

INITIAL

____ All copayments and deductibles are due at the time of delivery.

____ Bionics does not provide rental services.

____ An office visit charge may be made to you if you complete an evaluation/casting and decide not to proceed with the device. This charge varies from **$40 - $70** depending on the extent of the evaluation and casting procedure involved.

____ A **$20.00** charge will be made to you if you are a no call no show. We highly recommend calling our office and canceling an appointment **24** hours in advance.

I understand and agree to the above policies.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES
FOR BIONICS ORTHOTICS AND PROSTHETICS

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.

If you have any questions about this notice please contact
Kevin E. Calvo CPO (858) 270-9972

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means that any of your written and oral health information, including your demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

We are strongly committed to protecting your medical information. We create a medical record about your care because we need the record to provide you with appropriate treatment and to comply with various legal requirements. We transmit some medical information about your care in order to obtain payment for the services you receive, and we use certain information in our day to day operations. This notice will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use and or disclosure of your medical information. We will also ask that you acknowledge receipt of this Notice the first time you come to our facility because the law requires us to make a good faith effort to obtain your acknowledgement.

We are required by law to:

Make sure that any medical or health information that we have that identifies you is kept private,
and will be used or disclosed only in accord with this Notice of Privacy Practices and applicable law;

Give you this Notice of our legal duties and our privacy practices; and

Abide by the terms of the Notice or Privacy Practices that is in effect from time to time.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Protected Health Information for Treatment, Payment and Healthcare Operations.

Your protected health information may be used and disclosed by your Orthotist or Prosthetist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health care information may also be used and disclosed to pay your health care bills and to support the operation of this facility.

Following are examples of the types of uses and disclosures of your protected health care information that this facility is permitted to make. We have provided some examples of the types of each use or disclosure we may make, but not every use or disclosure in any of the following categories will be listed.

For Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party. For example we would disclose your protected health information, as necessary, to the physician that referred you to us. We will also disclose protected health information to other health care providers who may be treating you.

For Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We may also tell your health plan about an orthotic or prosthetic device you are going to receive to obtain prior approval or to determine weather your plan will cover the device.

For healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this facility. These activities include, but are not limited to, quality assessment activities, employee review activities, legal services, licensing, and conducting or arranging for other business activities. We may share your protected health

information with a third party "business associates" that perform various activities (e.g. billing, transcription services) for this facility. Whenever an arrangement between our facility and our business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Alternatives: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Appointment Reminders: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sign In Sheets: We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call your name in the waiting room when the practitioner is ready to see you.

Sale of the Practice: If we decide to sell this practice or merge or combine with another practice, we may share your personal health information with the new owners.

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke our authorization, at any time, in writing. You understand that we can not take back any use or disclosure we may have made under the authorization before we received your written revocation and that we are required to maintain a record of the medical care that has been provided to you. The authorization is a separate document, and you will have the opportunity to review any authorization before you sign it. We will not condition your treatment in any way on whether or not you sign any authorization.

C. Other Permitted and Required Uses and Disclosures That May Be Made Either With Your Agreement or the Opportunity to Reject.

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information then the treating practitioner may, using their professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we my disclose to a member of your family, a relative, a close friend or any other person you identify, orally or in writing, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interests based on our professional judgment. We may use or disclose you protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition.

D. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization Or Opportunity to Object

We may use or disclose your protected health information in the following situations with out your authorization or providing you the opportunity to object.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. A disclosure under this exception would only be made to somebody in a position to help prevent the threat to public health.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. We will only make this disclosure if you agree or when required or authorized by law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Military and Veterans: If you are a member of the military, we may release protected health information about you as required by military command authorities.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes might include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the facility's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: Under certain circumstances, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conditioning national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs that provide benefits for work-related illnesses and injuries.

Inmates: We may use or disclose you protected health information if you are an inmate of a correctional facility and your practitioner created or received your protected health information in the course of providing care for you.

Required Uses and Disclosures: Under the law, we must make disclosures of you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.

2. YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information contained in your medical and billing records and any other records that your practitioner uses for making decisions about you, for as long as we maintain the protected health information.

To inspect and copy your medical information, you must submit a written request to the Privacy Contact listed on the first and last pages of this notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

We may deny your request in limited situations specified in the law. For example, you may not inspect or copy psychotherapy notes,; or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain other specified protected health information defined by law. In some circumstances, you may have a right to have this decision reviewed. The person conducting the review will not be the person who initially denied your request. We will comply with the decision in any review. Please contact our Privacy Contact if you have any questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Orthotist or Prosthetist is not required to agree to a restriction that you may request. If your practitioner believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. IF your practitioner does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your practitioner.

You have the right to request to receive confidential communications from us by alternative means or at an alternate location. We will accommodate reasonable requests. We may also condition this accommodation by asking for your information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your practitioner amend your protected health information. This means you may request an amendment of your protected health information contained in your medical and billing records and any other records that your practitioner uses for making decision about you, for as long as we maintain the protected health information. You must make your request for amendment in writing to our Privacy Contact, and provide the reason or reasons that support your request.

We may deny any request that is not in writing or does not state a reason supporting the request. We may deny your request for an amendment of any information that:

1. Was not created by us, unless the person that created the information is no longer available to amend the information;
2. Is not part of the protected health information kept by or for us;
3. Is not part of the information you would be permitted to inspect or copy; or
4. Is not accurate and complete.

If we deny your request for amendment, we will do so in writing and explain the basis for the denial. You have the right to file a written statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures that we have made, if any, of your protected health information. This right only applies to disclosures for purposes other then treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It also excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You must submit a written request for disclosures in writing to the Privacy Contact. You must specify a time period, which may not be longer than 6 years and cannot include any date before April 14, 2003. You may request a shorter timeframe. You have the right to one free request within any 12 month period, but we may charge you for any additional requests within the same 12 month period. We will notify you about the charges you will be required to pay, and you are free to withdraw or modify your request in writing before any charges are incurred.

You have the right to obtain a paper copy of this notice from us, upon request to our Privacy Contact, or in person at our office, at any time, even if you have agreed to accept this notice electronically. You may obtain a copy of this notice at our website, www.bionicsoandp.com.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you in any way for filing a complaint, either with us or with the Secretary.

You may contact our Privacy Contact, Kevin E. Calvo CPO FAAOP at (858) 270-9972 or at bionics@sbcglobal.net for further information about the complaint process.

4. CHANGES TO THIS NOTICE

We reserve the right to change the privacy practices that are described in this Notice of Privacy Practices. We also reserve the right to apply these changes retroactively to Protected Health Information received before the change in privacy practices. You may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of your next appointment, or accessing our website.

This notice was published and becomes effective on April 14, 2003.

ACKNOWLEDGEMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICES AND/OR MEDICARE SUPPLIER STANDARDS

I certify that I have received and read a copy of the Bionics Orthotics and Prosthetics Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Bionics health care operations. The Notice of Privacy Practices also describes my rights and Bionics' duties with respect to my protected health information. The Notice of Privacy Practices is posted in each Bionics location.

Bionics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a copy of the Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, by asking for one at my next appointment or I can view it on Bionics' website at www.bionicsoandp.com.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

BIONICS ORTHOTICS AND PROSTHETICS

3737 Moraga Avenue, Suite B107
San Diego, CA 92117
858-270-9972
858-270-2361 (fax)

CONFIDENTIAL REQUEST FOR RELEASE OF MEDICAL RECORDS

I understand that the following release is to be used between Bionics Orthotics and Prosthetics and my prescribing physician, to obtain records, if necessary, in order to provide information to Bionics or my insurance company. I understand that I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

Physician's Name: _____

Facility Name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I hereby request that my medical records be released to:

Bionics Orthotics and Prosthetics
3737 Moraga Avenue, Suite B107
San Diego, CA 92117
858-270-9972
858-270-6560 (fax)

Patient's Name:_____ Date of Birth:_____

Signature:_____ Date:_____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED