BOAS SURGICAL

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name:	First Name :	Middle Initial:	Nickname:
Birth Date: / /	Gender: ❑ M ❑ F	Height:	Weight:
Social Security No.:	Email Address:		
Home Phone:	Cell Phone:	Work Phone:	Other Phone:
Home Street Address:		City:	State & Zip Code:

Reason For Visit:

Referring Physician:	Primary Physician:	Are you diabetic? ❑ Yes ❑ No If Yes, Treating Physician:	
Foot Ulcers? ❑ Yes ❑ No	Amputee? ❑ Yes ❑ No	Date of Amputation:	
Allergies To Materials?	Other Medical Conditions:		
Emergency Contact:	Emergency Contact Address:	Emergency Contact Phone:	Relationship:

INSURANCE INFORMATION

Is your condition the result of an injury? ❑ Yes ❑ No	Date of Injury:	If yes, what type of injury was sustained?
Was injury work related? ❑ Yes ❑ No	Employer's Name / Address:	Claim Number / Carrier Information:
Was injury the result of an auto accident? ❑ Yes ❑ No	Adjuster's Name / Phone Number:	Claim Number / Carrier Information:

Responsible Party :	Address:		Phone#:	Relationship:
Primary Insurance:	Policy / Group#:	Name of Subscriber:	Date of Birth:	Relationship:
Secondary Insurance:	Policy / Group#:	Name of Subscriber:	Date of Birth:	Relationship:

I certify that the information I have provided is true, accurate, and complete. *When the above-listed patient is a minor:* As parent and/or guardian, I give my consent for Boas Surgical, Inc. to treat my son/daughter for the device prescribed by his/her physician.

Signature of Patient, Guardian, or Other Responsible Party *Date* *Relationship*

Printed Name of Guardian, or Other Responsible Party

FINANCIAL POLICY

Thank you for choosing Boas Surgical, Inc. Our primary mission is to deliver the best care available. Please understand that payment of your bill is part of this treatment and care.

For patients with insurance we are committed to work with your carrier to maximize your benefits and bill them directly for reimbursement when possible. In that regard, we make every attempt to verify your insurance benefits, and obtain authorization when required. However, insurance verification and authorization are not a guarantee of payment. You are ultimately responsible for payment of your account. Our financial counselors are available to answer any specific billing questions you may have.

Please note the following important policies:

- Patients without insurance are required to pay in full on the day of delivery.
- Any deductible, coinsurance and/or copayment estimated as patient responsibility is due on the day of delivery.
- Custom-made items require 50% of estimated patient responsibility be paid on the day of casting before the item can be put into production. The balance is due on the date of delivery.
- If a custom-made item is cancelled for *any* reason after production begins, the patient and/or insurance carrier will be billed and held responsible for expenses incurred.
- Boas Surgical, Inc. utilizes an outside collection agency to collect on any outstanding accounts which do not maintain an active status with our practice.
- Upon signature of this financial policy, any balances incurred before, during or after this visit, will be subject to the terms of this policy. Guarantor of any account placed with a collection agency, will be responsible for all collection fees and/or legal fees associated with the collection of past due balances.
- Should your account be turned over to a collection agency, payment of any delinquent balance is required prior to being seen again in any of our offices. In addition, any future services will require payment in *full* at the time of service.
- A $25 fee is charged for more than 3 missed/canceled appointments (without 24-hour notice) a year.
- A $25 fee is charged for returned checks.

To make the cost of your care as easy and manageable as possible, we offer several payment options:

- Cash or Check
- Visa, MasterCard or Discover Card
- Convenient Monthly Payment Plans from CareCredit

My signature below indicates I have read and agree to the terms of this financial policy.

______________________________ ______________________

Signature of Patient / Guarantor **Date**

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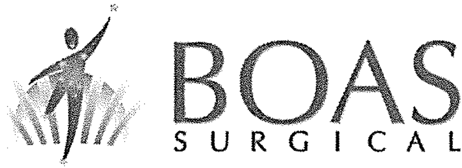
Printed Name



ASSIGNMENT OF BENEFITS
AUTHORIZATION TO RELEASE INFORMATION
NOTICE OF PRIVACY PRACTICES
COMMUNICATION CONSENT

Assignment of Benefits

Assigning benefits to Boas Surgical, Inc. means that you[i] request payment of Medicare, Medicaid, or private insurance benefits be made to Boas Surgical, Inc. for any covered services furnished by Boas Surgical, Inc. In connection with this, you understand and agree that you are responsible for the following expenses:

- any service your insurance plan deems "non-covered" or exceeds the benefit limits under your insurance plan
- any copayment, coinsurance and/or deductible
- any amount your insurance plan denies because you were not insured on the date of service

Authorization to Release Information

Authorization to release information means that you authorize any holder of medical information about you, to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE, and its agents, or to any private insurance company, any information needed to determine these benefits or the benefits payable for related services.

Notice of Privacy Practices

I certify that I have been advised of an available copy of Boas Surgical, Inc.'s Notice of Privacy Practices at www.boassurgical.com. This notice 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 health care operations. This notice also describes my rights and Boas Surgical, Inc.'s duties with respect to my protected health information.

Communication Consent

I authorize Boas Surgical, Inc. and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Phone / Answering Machine	Yes ______	No ______
Work Phone / Voice Mail	Yes ______	No ______
Cell Phone / Voice Mail	Yes ______	No ______

If you would like information released to someone other than yourself, please complete the following:

Name ___________________________ Phone ____________________ Relationship ____________________

Name ___________________________ Phone ____________________ Relationship ____________________

Your signature acknowledges receipt of, and agreement with the terms within this document, as well as:

1. **Your desire to assign your benefits to Boas Surgical, Inc.,**
2. **Your authorization to release any information needed to determine benefits to your insurance carrier,**
3. **Your receipt of notification of where to access Boas Surgical, Inc.'s Notice of Privacy Practices,**
4. **Your receipt of Boas Surgical, Inc.'s Financial Policy,**
5. **Your receipt of Boas Surgical, Inc.'s Service Policy and Warranty, Patient Bill of Rights, Patient Responsibilities, and Medicare's Supplier Standards.**

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Signature of Patient / Guarantor **Date**

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Printed Name

[i] In this document, '*you*' and '*your*' refers to the patient, or authorized representative.