



RYAN FOOT AND ANKLE CLINIC, P.C.
LAWRENCE BROWN, D.P.M., D.A.B.P.S.

BOARD CERTIFIED, AMERICAN BOARD OF PODIATRIC SURGERY
BOARD CERTIFIED, AMERICAN BOARD OF PODIATRIC ORTHOPEDICS
AND PRIMARY PODIATRIC MEDICINE
FELLOW, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS
FELLOW, AMERICAN COLLEGE OF FOOT AND
ANKLE ORTHOPEDICS MEDICINE

25511 VAN DYKE, SUITE 100
CENTER LINE, MI 48015
TELEPHONE: (586) 758-5770
FACSIMILE: (586) 758-6134

WE ARE PLEASED TO HAVE YOU WITH US

We wish to welcome you to our office. Please answer these questions to help us become better acquainted. If you need any help, please don't hesitate to ask.

NAME _____ DATE OF BIRTH _____ AGE _____

ADDRESS: _____ CITY _____ ZIP _____

HOME # _____ WORK # _____ ALT # _____

SOCIAL SECURITY# _____ MARITAL STATUS _____ SEX _____

EMAIL ADDRESS _____

EMPLOYER _____ OCCUPATION _____

INSURANCE COMPANY _____ POLICY HOLDER _____

POLICY HOLDER NAME AND DATE OF BIRTH _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE _____

EMERGENCY CONTACT NAME AND NUMBER _____

I hereby give permission to Dr. Lawrence Brown or Dr. Steven Magier to administer treatment and to perform such minor operative procedures as deemed necessary in the diagnosis and/or treatment of my foot or ankle condition.

I request that payment of authorized insurance benefits be made on my behalf to:

Ryan Foot & Ankle Clinic, P.C./ Dr. Lawrence Brown/ Dr. Steven Magier for any services furnished me by that physician/clinic/supplier. I authorize this clinic to release any information pertinent to my case to my insurance company (companies).

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company. I understand that it is my responsibility to know my insurance plan and all applicable limitations/restrictions and/or copays and deductible for which I may be charged.

A photocopy of this assignment shall be considered as effective and valid as the original.

PATIENTS SIGNATURE _____ DATE _____



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INSURANCE AUTHORIZATION AND WAIVER FORM

PATIENT NAME _____

INSURANCE CARRIER _____

INSURANCE NUMBER _____

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO :

RYAN FOOT & ANKLE CLINIC, PC/ DR. LAWRENCE BROWN/DR. STEPHEN MAGIER FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN/CLINIC/SUPPLIER. I AUTHORIZE ANY HOLDER OF HOSPITAL AND/OR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR MY PRIVATE INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAYMENTS AND/OR DEDUCTIBLES. I WILL ALSO BE RESPONSIBLE FOR ANY SERVICES THAT ARE NOT COVERED BENEFITS BY MY INSURANCE CARRIER. IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE COVERAGE.

I GIVE PERMISSION TO RYAN FOOT & ANKLE CLINIC, PC AND STAFF TO PERFORM THE FOLLOWING ACTS:

TO TRANSMIT MY INSURANCE CLAIMS ELECTRONICALLY, TO CALL INSURANCE COMPANIES REGARDING BENEFITS AND CLAIM STATUS; TO SEND OFFICE REMINDER, RECALL AND/OR WELCOME AND BIRTHDAY GREETINGS VIA MAIL; TO SEND ALL LABS AND INFORMATION THROUGH THE LAB DELIVERY SYSTEM; TO CALL ME BY NAME IN THE OFFICE AND WAITING ROOM; AND TO CALL ME ON THE TELEPHONE AND LEAVE MESSAGES.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

PATIENT'S SIGNATURE _____ DATE _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.