Welcome To *Advanas Foot & Ankle Specialists®*

We want to thank you for trusting ***Advanas Foot & Ankle Specialists®*** with your healthcare needs.

At ***Advanas Foot & Ankle Specialists®*** we pride ourselves on being a pleasant environment with caring staff whose goal is to provide the latest in treatment options for every foot and ankle problem.

We understand you have many options when it comes to your foot and ankle care and we are honored that you have chosen us.

Again, let me thank you for your confidence in us.

Sincerely,

Doctors and Staff of Advanas Foot & Ankle Specialists

Patient Demographics

Advanas Foot & Ankle Specialists/Sturgis Surgi-Care

Patient Information:

Name: (First)_____(Middle Initial)_____(Last)_____

Address:_____**City, State:**_____**Zip Code:**_____

Date of Birth:_____ **Sex:** ( )Female ( )Male **Marital Status:** ( )Single ( )Married ( )Divorced ( )Widowed

Home Phone #:_____ **Cell Phone #:**_____

Social Security #: _____

Email Address:_____

Race: ( )White ( )Black/African American ( )Latino/Hispanic ( )Other

Ethnicity: ( )Hispanic/Latino ( )Other **Preferred Language:** ( )English ( )Spanish ( )Other

Employer:_____ **Occupation:**_____

Employer Address: _____ **City, State:** _____**Zip Code:**_____

Employer Phone #: _____

Guarantor/Responsible Party:

Full Name:_____ **Date of Birth:**_____ **S.S. #:**_____

Relationship to Patient: ( )Self ( )Spouse ( )Parent ( )Guardian ( )Other

Employer:_____ **Occupation:** _____

Employer Address:_____**City, State:**_____**Zip Code:**_____

Employer Phone #: _____

Who is your Primary Care Physician?

Name: _____

Physicians Address/Location: _____

Date of last visit?_____ **Phone #:** _____

Preferred Pharmacy:_____ **Location:**_____

Foot Health Information:

What is your current foot/ankle condition? _____

When did it begin? _____

Have you seen another doctor for this condition? _____ **Whom?**_____

How have you treated this condition so far?_____

How did you hear about us? We would like to thank them!

Name: _____**Phone #:** _____

Address: _____**City, State:**_____**Zip Code:**_____

Signature of Patient or Guardian: _____***Date:*** _____

***OFFICE USE ONLY*: Entered By:**_____**Date**_____

Public: Master File - Overall: Clerical - Welcome To Our Office

Notifications	Please Initial In Box
I hereby give the physicians at Advanas Foot & Ankle Specialists permission to examine and treat my feet. I also authorize the release of medical or other information necessary to process any insurance claim and authorize payment of medical benefits to Advanas Foot & Ankle Specialists. I certify that the information given to the staff at Advanas Foot & Ankle Specialists is true and correct to the best of my knowledge and will notify Advanas Foot & Ankle Specialists if any of this information changes.	
PATIENT RIGHTS AND RESPONSIBILITIES: • I have been informed of my patient rights and responsibilities.	
ADVANCE DIRECTIVES: • I have been informed of my rights to formulate an Advance Directive and understand that I am not required to have an Advance Directive in order to receive medical treatment in this health care facility. • I understand that it is the policy of this practice to resuscitate all patients that require resuscitation in order to maintain their vital functions. • I understand that in the case of a medical emergency, I may be transferred to the local hospital. • If you have an Advanced Directive, you must be aware that we do not honor them, we will do everything in our power to save you as long as you are in the office.	
FINANCIAL POLICY: I have read, understood and agree with the financial policy. I also understand that I may receive a copy upon my request.	
Consent to release: I authorize my physician at Advanas Foot & Ankle Specialists to obtain any outside information regarding my health or prescription history from external sources.	
DISCLOSURE OF OWNERSHIP: Advanas Foot and Ankle Specialists PLC is owned by Dr. Bussema D.P.M, Dr. Bickle D.P.M, and Dr. Monfore D.P.M. Please be advised of the following: • The facility may have a financial relationship with your physician as indicated above. • A schedule of typical fees for services provided by the facility may be available at your request. • You may have the right to choose where to receive services including an entity in which your physician may have a financial relationship.	

YOUR CONFIDENTIAL COMMUNICATIONS

Persons whom we can contact regarding your treatment, care, appointments, or financial arrangements.

Emergency Contact:_____Phone#:_____
Phone # we can leave a detailed message on:_____
Spouse (Name):_____
Children (Name):_____
Care Giver (Name):_____
Power of Attorney (Name):_____
Lawyer (Name):_____
Other(Name(s)):_____

If no one is listed in this section we will only be able to speak to you regarding your personal health information.

I HAVE RECEIVED A COPY OF ADVANAS FOOT & ANKLE SPECIALISTS NOTICE OF PRIVACY PRACTICES.

Patient Name (Printed): _____ Patient DOB:_____
Patient/Guardian Signature:_____
Date:_____

PATIENT RIGHTS AND RESPONSIBLITIES

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of

Advanas/ Sturgis SurgiCare

The patient has the right to

- ***To*** be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need of privacy
- ***To*** an environment that is safe and secure for self and property.
- ***To*** confidentiality of information gathered during treatment
- ***To*** prompt and reasonable response to questions and requests.
- ***To*** know who is providing and is responsible for his or her care.
- ***To*** know what patient support service are available, including whether an interpreter is available if he or she does not speak English
- ***To*** know what rules and regulations apply to his or her conduct.
- ***To*** be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- ***To*** be given, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Advance Directives.
- ***To*** receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- ***To*** receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- ***To*** receive impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- ***To*** receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- ***To*** know if medical treatment is for purposes of experimental/research and to give his or her consent or refusal to participate in such experimental research.
- ***To*** express grievances regarding any violations of his or her rights, through the grievance procedure of health care provider which served him or her.
- ***To*** participate in all aspects of health care decisions, unless contraindicated by concerns for their health.
- ***To*** appropriate assessment and management of pain

The patient is responsible

- ***For*** providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- ***For*** reporting unexpected changes in his or her condition to the health care provider.
- ***For*** reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- ***For*** following the treatment plan recommended by the health care provider.
- ***For*** keeping appointments and when he or she is unable to do so for any reason, for notifying the Facility
- ***For*** his or her actions if he or she refuses treatment or does not follow the health care providers instructions.
- ***For*** assuring that the financial obligations of his or her health care fulfilled as promptly as possible.
- ***For*** following Facility rules and regulations affecting patient care and conduct.
- ***For*** consideration and respect of the Facility staff and property.
- ***For*** asking what to expect regarding pain and pain management.

If you have any concerns or complaints regarding your care, treatment, or services, please contact us at (269)651-2320.

Financial Policy

Advanas Foot and Ankle Specialist believes part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy. We are committed to your treatment being successful. Please understand payment of your bill is considered as part of your treatment.

Payments:

Payment will be accepted by proof of coverage (insurance), cash, check, money order, Visa, Mastercard, American Express, Discover, PayPal, Care Credit, and HSA. You may also postdate a check or place a credit card on file. Any balance remaining after your insurance has been billed, will be placed on your credit card. Please ask the receptionist for a copy of our Quick Pay Verification form if you would like this option.

Insurance:

Due to the extremely large number of insurance companies, we cannot be acquainted or be in-network with all policies. Your policy is your responsibility to be familiar with, should you have questions, we will be of any assistance possible. We will not accept any Medicaid plans at this time.

The following are common terms associated with insurance:

- EOB – Explanation of Benefits: This is a statement from your insurance company of what they have allowed, paid, or denied.
- Deductible: The amount you are responsible for each year before any payment is made from your insurance company
- Co-Pay: A set fee you are legally responsible for at each office visit or procedure.
- Co-Insurance: A percentage of the services your insurance leaves you responsible for.
- In-Network: We have a contract with your insurance company.
- Out of Network: We do NOT have a contract with your insurance company.

Your insurance policy is a contract between you and your insurance company; therefore, it is your responsibility to familiarize yourself and verify network status with any physician's office you see.

As a courtesy, we will file a claim for you, as long as you provide a current insurance card, and assign the benefits to the organization. Therefore, please have your insurance card every time you visit the office. If the correct information is unable to be obtained at the time of service, it is your responsibility to pay your balance or reschedule your appointment.

You will receive a bill from us once your insurance company has paid, or your claim has been processed and denied. In rare cases, we must resubmit your claim several times, therefore while unusual it could be several months, to a year, before you are billed. Your insurance company may request additional information from you after we have filed a claim. Should information needed not be supplied in a timely fashion, is one way the claim may take longer to process. So please remember it is your responsibility to promptly answer any requests for information from your insurance company. Most insurance companies

will send you an EOB within 45 days. If you have not received an EOB from your insurance company, we encourage you to contact them to determine the status of your claim.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges of any services rendered. Patients are encouraged to contact their plans for clarification of benefits before services are rendered.

You must inform the office of all insurance changes, authorization requirements, and referral requirements. In the event the office is not informed, you will be responsible for any charges.

If you have two medical insurance plans, it is your responsibility to inform us which plan is your primary (first), and which is your secondary (second). You must inform us if one or both insurance plans change or are no longer in effect. Please note all billing is done through our billing office located in Sturgis, Michigan. You may receive notice from us or your insurance company with Advanas Foot and Ankle Specialist information.

We understand financial difficulties arise making it impossible to meet your financial obligations. If you are going through financial hardship or need to make payment arrangement, please submit in letter in writing to:
Advanas Foot and Ankle Specialists
Attn: Billing Department
PO Box 730
Sturgis, MI 49091
You may also phone a billing specialist for options available.

Self-Pay:

A minimum deposit of $200.00 or the actual charge, whichever is less, and any subsequent visit charges are due at the time of service rendered.

Workman's Compensation/Auto Accident Insurance:

If you are here as a result of a work-related injury, we are required to have a letter or statement authorizing your treatment from your employer or Workman's Compensation carrier. The letter should include the claim number, address, adjuster's name, and phone number. Your employer's human resource office should be able to assist you with obtaining this information. Without this information or necessary paperwork, you will not be able to seek care through our office.

Fees:

The fees for evaluation and treatment vary depending upon the complexity of your condition and the treatment required. Services provided by other health care organizations outside of Advanas Foot and Ankle Specialists may charge their own fees. (I.E. Pathology.)

If you would like a copy of our standard fee schedule, please send a written request, with a self-addressed envelope to:
Advanas Foot and Ankle Specialists
Attn: Billing Department
PO Box 730
Sturgis, MI 49091

You will be informed in advance if any procedures requiring prepayment, along with time of payment due.

Other fees that may occur:

- Medical records and duplicates- $35
- Returning over-the-counter product- varies
- Returning durable medical equipment- varies
- Duplicating receipts or itemized bills- $25
- Returned checks- $50
- Surgery cancellation -$150
- No show to appointments- $35

Collection:

Due to regulations and changes in the healthcare industry, we are required to secure payment. If your account has no action taken for a period of three months of statements rendered to your last known address, your account is subjected to collections. We take various actions to collect all payments due to our organization as it is part of a successful treatment with us. Collections may include court actions if we have not heard from you and acceptable arrangements are made. The sooner arrangements are made with our billing department, the less cost you are likely to occur. Additionally, notification will be sent by mail, to your last known address. While in collections you may not be able to be seen by our physicians until arrangements are completed.

If you have any questions regarding your treatment, your account, or our office policies, please phone during business hours. Our main concern is taking care of you and your loved ones. Please do not hesitate to talk with our Billing Department or Director of Operations should you find yourself in a situation you feel needs discussed.

Product Return Policy:

Advanas is pleased to be able to offer quality products to patients. Most of our patients often have great success when it comes to using our products. In the case that a patient is not pleased with their purchase or simply wants to return their product, Advanas reserves the right to charge a restocking fee. All products must be unused or defective-free to be returned. No used products will be returned.

Thank you for your continued support.

Notice Of Privacy Practices

Effective Date: *1/1/2022*

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.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations: We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the podiatric care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you to

remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be

using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, 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 interest based on our professional judgment.

Disaster Relief: We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our Medical Records Office. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a

readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Medical Records.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, simply ask at the front desk, or mail a request to 102 S. Lakeview Ave. Sturgis MI, 49091.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will

post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, by mail at 102 S. Lakeview Ave. Sturgis, MI 49091. All complaints must be made in writing.

You will not be penalized for filing a complaint.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.