MICHAEL A. ROBINSON, D.P.M., M.P.H.
F.A.A.P.S.M.
1443 BEACON STREET
BROOKLINE, MASSACHUSETTS 02146
(617) 277-2662

Dear Medicare Patient,

The visit and/or procedures (except orthotics) which Dr. Robinson performed on you today will be submitted to Medicare for you. However, due to Medicare restrictions, there may be a time when Medicare will deny payment.

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary under Medicare program standards, Medicare may deny payment for that service.

Some of their reasons may be a) Medicare may deem the service as routine foot care (though we will have submitted it differently) or b) Medicare may decide that too many services were rendered for your condition, even though the service may be medically necessary for your situation.

Should this situation occur, we will then bill the patient directly. In order to comply with Medicare regulations, we are obligated to bring this situation to your attention and ask you to verify that we have done so by signing and dating the bottom. Please note that we are also obligated to ask you to sign and date this document each time you come in for a visit.

Thank you.

PATIENT'S AGREEMENT

I have read the above statements and realize that Medicare may deny payment. If Medicare denies payment, I agree to be personally and fully responsible for payment.

SIGNATURE	DATE

INSURANCE WAIVER FORM

Patient Name: ____________________

I understand that the office, Sports Podiatry Resource, will bill my insurance company for some or all of the medical charges incurred by me. I also understand that if any or all of the charges are not reimbursed by my insurance company, I will be responsible for the payment of those charges. The reasons for denial may include, but not be limited to, lack of referral, deductible, coverage terminated or service not included in my plan.

SIGNED	DATE
X	

SPORTS PODIATRY RESOURCE, INC

PATIENT INFORMATION

Last Name:		First Name:	
Street Address:		Apt #	Unit#
City:		State:	Zip:
Birth Date:	Age:	Gender:	Occupation:
Home phone:			Employer:
Cell phone:			Street:
Email (admin. purposes only):			City/State:
Social Security:			Work Phone:

RESPONSIBLE PARTY FOR COLLEGE STUDENTS, MINORS AND DEPENDANTS

Parent or guardian:		
Relationship to patient		
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Work Phone :	Email:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Subscriber:	Subscriber:
Subscriber's date of birth:	Subscriber's date of birth:
Relationship of patient to subscriber. Circle one: Self, spouse, life partner, son, daughter, legal dependent.	Relationship of patient to subscriber. Circle one: self, spouse, life partner, son, daughter, legal dependent.

PRIMARY CARE PHYSICIAN

Primary Care Physician or Assigned Facility:	
Phone Number:	Date last seen:

OTHER INFORMATION

How did you hear about us?
Reason for today's visit:
Athletic Activity:
Occupational activity (circle): Sitting, Standing, Walking, Ladder Climbing, Frequent use of stairs, Other:

Initial:

X_____ Missed appointments or cancellations without 1 full business days' notice incur a $75 fee. We do not make reminder calls.

X_____ There is a 1.5%monthly (18%yearly) finance charge on patient balances aged over 30 days.

X_____ Custom orthotics and footwear require payment in full before they can be fabricated and there are no refunds.

Signed____Date_________________________

SPORTS PODIATRY RESOURCE
MICHAEL A. ROBINSON DPM, MPH
1443 BEACON STREET
BROOKLINE, MA 02146

DATE ____________

NAME: ______________________________ FAMILY DOCTOR: ____________________

AGE: _____ HEIGHT: _________ WEIGHT: _____ RECENT GAIN ( ) LOSS ( ) YES ( ) NO (

Please indicate by an (x) in the proper column. ("Y"=Yes, "N"=No)

History of	Y	N
Angina/Chest Pain		
Arthritis		
Asthma		
Bleeding Tendencies		
Blood Disorders		
Bronchitis		
Cancer/Growths/Tumors		
Deprssion/Psychiatric Treatmt		
Diabetes		
Fracture		
Gout		
Heart Disease		
Hepatitis		
Hiatal Hernia/Reflux		
High Blood Pressure		
HIV Positive		
Kidney Disease		
Liver Disease/Jaundice		
Lung Disease		
Murmur/Mitral Valve Prolapse		
Neurological Disorder		
Seizures		
Shortness Breath on Exertion		
Stroke		
Ulcers		

History of	Y	N
Venereal Disease		
Other:		

Prosthesis/aids	Y	N	List
Artificial Limb			
Cane/Crutches/Brace/Walkr			
Contact Lenses/Glasses			
Dentures/Crowned Teeth			
Foley Catheter			
Hearing Aid			
Metal Implants			
Ostomy Equipment			
Pacemaker			
Other:			

Allergies	Y	N	List
Drugs			
Food			
Hay Fever			
Skin Conditions			
Other:			

Habits	Y	N	Name & Amount
Alcohol Use			
Anabolic/Androgenic Steroid Use			
IV Drug Use			
Recreational Drug Use			
Tobacco Use			

(Continued on other side)

If you answered YES to any of the previous questions, please explain: ____________

____

MEDICATIONS

Presently Taking	Dosage

PREVIOUS HOSPITALIZATION AND/OR SURGERIES: ____________________________

____

____

HAVE YOU, OR HAS ANYONE IN YOUR FAMILY HAD ANY COMPLICATIONS FROM ANESTHESIA?
YES(   ) NO(   )   IF YES, PLEASE EXPLAIN.

____

____

____

HAVE YOU EVER HAD A SPRAIN, DISLOCATION OR FRACTURE? YES(   ) NO(   )
IF YES, PLEASE EXPLAIN: ________________________________

____

____

ANY OTHER SIGNIFICANT MEDICAL INFORMATION OF WHICH WE SHOULD BE AWARE?
YES(   ) NO(   ). IF YES, PLEASE EXPLAIN.

____

____

____

INFORMATION ABOUT ORTHOTICS

(This is informational and not an order for orthotics)

Many conditions may arise from poor foot mechanics. As part of your treatment, foot orthotics may be prescribed to address these abnormal biomechanics. Orthotics are an integral part of your treatment in conjunction with other treatments such as medications, injections, exercises, castings/strappings, changes in shoes , surgery, ect.

Orthotics are prescribed custom devices that are fabricated to your specifications and can only be worn by you. In order to fabricate orthotics a mold or scan is taken of your feet.

The charge for orthotics is **$425** per pair. Most insurers do not cover orthotics. We will not bill insurance companies for orthotics. If requested, you will be given a receipt and a letter of medical necessity which you may submit to your insurer for possible reimbursement. Office visits are not included in the charge for orthotics.

Orthotics must be paid in full before the mold or scan can be released for fabrication. We accept MasterCard, Visa, Discover, American Express, Checks and Cash. There are no refunds for orthotics.

If orthotics charges ($425) not paid in full, a fee of $50 is required on the date of molding or scanning, with the balance of ($375) to be paid before orthotics can be fabricated. Due to space constraints, mold or scan will be stored for no more than six weeks after which they will be discarded without notice.

Orthotics take 2-3 weeks to be fabricated. We will call you when the orthotics are ready. Or send a postcard if we are not able to get in contact with you. Upon receipt of the post card, please call for an office appointment. This will be an office visit with Dr. Robinson and it is not included in the charge for orthotics. The orthotics may not fit all or any of your current shoes, therefore, you may need to purchase new shoes.

Orthotics usually provide 2-3 years of improved foot function and in many cases positively affecting other joints such as ankles, knees, hips and lower back. Yearly checkup for orthotics is needed to assure they continue to work as prescribed.

Date________________

Patient Name Printed______________________________________

Patient Signature____

01/18

NOTICE OF BILLING POLICIES AND GUARANTY OF PAYMENT

Payment of Co-Pays, Deductibles, Coinsurance or Balances Due

Co-pays for office visits must be paid at the time of the office visit.

After your visit as a participating provider, this office will submit claims to your insurance carrier for services rendered to you.

Upon your receipt of the Explanation of Benefits (EOB) statement from your insurance carrier, your insurer will indicate the amounts paid to this office by your insurer, per contract.

The EOB will indicate the amounts the insurer has assigned for payment by you to this office, per your contractual obligations. Those amounts not payable by your insurer, assigned to you, may be deductibles or other co-insurance.

You are responsible for any applicable amounts assigned by the insurer for payment to this office by you, the insured, within 30 days of receipt of our billing statement to you.

Payment of your co-pays/deductibles/coinsurance is a mandatory requirement of your insurance contract and this office will notify your insurance carrier of any default.

Any amounts/balances due not paid to this office will be subject to a through collection process included reporting to credit agencies.

Also please note that if this office collects any overpayment of funds reimbursed directly from your insurance carrier or any overpayment which may be due to you, such funds will be forwarded to you or the insurer, as a applicable.

You will not be seen by Dr. Robinson until the section below is fully completed

Guarantee of Payment

I have read the policies concerning payment for services. I personally guaranty of payment of services not covered by my insurer and I understand that a credit card must be on record to pay for out of pocket expenses not covered by my insurer. I authorized the use of this card, if after the receipt of my Explanation of Benefits statement from my insurer and subsequent billing by this office that I incur a deductible or other co-insurance which is due in payment for services/products provided by Michael A. Robinson, DPM/Sports Podiatry Resources, Inc.

Credit card: Visa______ MC______ Discover_____AMEX______

Number:____

Expiration date:__________________________ Security code:__________

Patient Name:_________________________DOB__________

Patient/ Guardian Signature____

We understand everyone's concern and we hope that you understand our concern to be guaranteed payment for our services. Having a credit card on file is a routine in many industries including every time you check into a hotel. The health care industry has many safe guards and our office will be securing your information with confidentiality in a safe. Your cooperation is greatly appreciated. Thank you.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____
Patient Name (please print)

____
Date

____
Parent or Authorized Representative (if applicable)

____
Signature

SPORTS PODIATRY RESOURCE

[Insert name of Practice]

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. 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 a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

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 protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a 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.

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. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health 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. We may use or disclose 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, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent

threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

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. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

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; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

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.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $___ for each page, $___ per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency) Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf We will not be bound unless our agreement is so memorialized in writing

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person ______________________

Telephone ______________________ Fax: ______________________

E-mail ______________________

Address ______________________