MOLINA ORTHO LABS INC. DBA CROWN CITY ORTHOPEDIC
PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Birth date: / /

Height:	Weight: lbs	Affected side (circle one): Right Left Both	Are you here related to an injury? Yes No Type: Job Auto Other DOI: / /	Age:	Gender: ❑ M ❑ F

Street address:	Home phone no.: ( )	Cell phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Email:

INSURANCE INFORMATION

(Only if different from above) Subscriber's name:	Birth date: / /	Address:	Phone no.: ( )

Is this person a patient here? ❑Yes ❑ No

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please indicate primary insurance: ❑ Anthem Blue Cross ❑ United Healthcare ❑ Blue Shield ❑ Health Net ❑ Scan ❑ Aetna ❑ Cigna ❑ Humana ❑ Care 1st ❑ Other:

Group no.:	Insurance ID no.:	Copay/Coinsurance: $	Method of payment:

Is this patient covered by a secondary insurance? **(excludes Medi-cal)** ❑ Yes ❑ No

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Insurance ID no.:

(Please give your insurance card and a photo ID to the receptionist)

IN CASE OF EMERGENCY

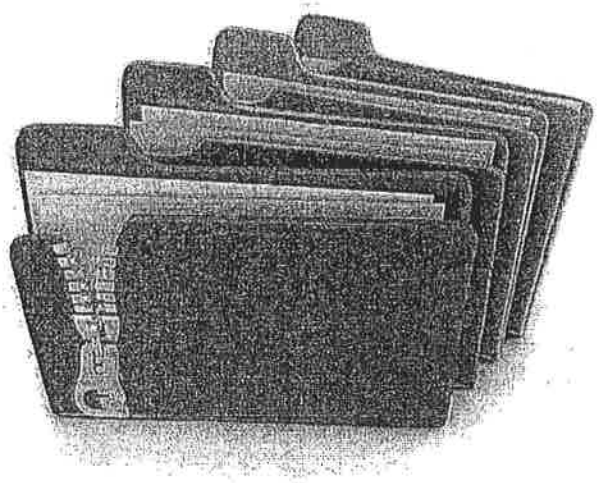
Name of relative or friend:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Crown City Orthopedic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Molina Orthopedic Labs., Inc. dba Crown City Orthopedic

610 N. Santa Anita Ave., Ste#100
Arcadia, CA 91006
www.crowncityortho.com
Office Manager
Ph (626) 431-2890 Fx (626) 431-2892



Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We solely provide orthotics and prosthetics. We are not a physician's office and do not have any physicians in our office. We do not provide home medical equipment.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: September 01, 2014

This Notice of Privacy Practices applies to the following organizations.

Molina Orthopedic Labs., Inc. dba Crown City Orthopedic

Office Manager
Ph (626) 431-2890 Fx (626) 431-2892
email: info@crowncityortho.com

Molina Orthopedic Labs., Inc. dba Crown City Orthopedic

610 N. Santa Anita Ave., Suite 100, Arcadia, CA 91006
Phone (626) 431-2890 Fax (626) 431-2892

Acknowledgment of Receipt of Privacy Practices

Molina Orthopedic Labs., Inc. dba Crown City Orthopedic reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the "Notice of Privacy Practices", for Molina Orthopedic Labs., Inc. dba Crown City Orthopedic.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____/_____/_____
Date

_____
Signature of Patient Representative/Guardian
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative/Guardian to Patient

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Waiver Form

INSURANCE CONDITIONAL COVERAGE REQUEST

Patient/Guardian: Effort has been made to verify your eligibility and benefits for orthotics, prosthetics, and/or DME coverage with your insurance company. You are requested to sign this form in the event that you do not have proper coverage for the services received here. If it is determined that you are not covered by your insurance for our services, you will be financially responsible for those services.

- If it is determined that you are not covered by your insurance for our service, then you will be financially responsible without refund or credit.
- If your insurance company denies payment, regardless of prescription or authorization, then you will be financially responsible without refund or credit.
- Items are non-returnable due to health, hygienic and medical safety regulations; but adjustments or re-make may be covered within the first 90 days.
- Any additional work, services, or products will result in additional charges.
- Crown City Orthopedic requires a deposit of 50% for any non-covered or out of pocket item/service.
- Insurance co-pay/co-insurance is to be paid in full before the item is provided.
- If any invoice amount is difficult, then terms of payment will be negotiated with Crown City Orthopedic.
- Monthly payments are due by the last day of each month and a separate Monthly Payment Agreement is to be signed.
- If payments are not made in a timely manner, then the past due balance will be sent to collections.
- Patient authorizes the release of any medical information to determine if benefits are payable for services rendered.

I have read this form and understand that if I am not eligible for service coverage with Molina Orthopedic Labs., Inc dba Crown City Orthopedic or my insurance company, I will be held financially responsible for services rendered by them. Assignment of benefits: I authorize payment of medical benefits to Crown City Orthopedic for services received.

_____ _____/_____/_____

Name of Patient (Print or Type) Date

_____ _____

Signature of Patient/Guardian Relation to Patient

Credit/Debit Card on File Agreement

Co-pays: Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider(s) have paid their portion of your bill or any other patient(s) you have listed on this form and there is still an outstanding balance owed, Crown City Orthopedic will notify you via mail. If the balance owed is not paid within 30 days, Crown City Orthopedic will charge the balance to your credit/debit card. A copy of the charge will be mailed to you.

You are giving Crown City Orthopedic permission to automatically charge your credit/debit card on file for your outstanding balances or any other patient(s) balances you have listed on this form at time of service. Your information will not be shared or disclosed to any other facility, office or company.

I authorize Crown City Orthopedic to charge co-pays, coinsurances and outstanding balances on my account to the following credit/debit card:

Visa_____ MasterCard_____ Discover_____American Express_____

Credit Card Holder's Name: _____ (Please Print)

Credit Card # _____

Expiration Date: _____ CVC #: _____

This credit card on file is to be used for the following patient(s), please print name(s) below: (expires after 1 year)

Patient Full Name: _____ DOB: _____ / _____ /_____

Patient Full Name: _____ DOB: _____ / _____ / _____

Patient Full Name: _____ DOB: _____ / _____ / _____

Patient Full Name: _____ DOB: _____ / _____ / _____

Multiple Users: This card will only be authorized for the use of the credit/debit card holder, his/her minor(s), or any person(s) listed above. This agreement will expire for multiple users on an annual basis. If continued authorization is requested, another credit card agreement can be issued or a manager can verbally authorize and document the extension of an agreement.

Signature: _____ Date: _____