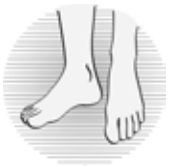


Sedona Foot & Ankle Specialists
Dr. Serj Nazarian, D.P.M
401 S. Calvary Way, Ste. A, Cottonwood, AZ 86326
928-282-3305

Dear Patient,

We would like to take this opportunity to welcome you to our practice and thank you for choosing Sedona Foot & Ankle Specialists to provide your foot and ankle care. As a part of our service we try to contain the ever rising cost of health care. In an effort to do this we have implemented this Financial Policy which we ask you to read and sign. We can provide you a copy of this policy if you so desire but we will keep the original for your patient chart.

INSURANCE BENEFITS AND COVERAGE
As a courtesy to you, our staff will submit your insurance claims for treatments rendered at this office. Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you ever have questions regarding your coverage, we will be happy to assist you in obtaining those answers. Ultimately you are responsible for all costs incurred during treatment with the exception of PPO, HMO and Preferred Provider adjustments. These adjustments are determined by the contract the doctor has with the individual insurance company. If your insurance does not accept assignment of benefits, or in other words, if they pay you rather than us, payment must then be made in full at the time of service. In such instances we will ask you to submit your own claim.

COPAYMENTS AND DEDUCTIBLES
Although we do accept assignment of insurance benefits, we require payments co-payments and patient portion amounts at the time of service.

UNINSURED PATIENT AND NON-COVERED BENEFITS
Full payment is due at time of service. We do accept cash, check, Visa and MasterCard. In some instances a payment plan may be made for patients without insurance or for medically necessary services not covered by your insurance. These plans will be made on a case to case basis. While we try to accommodate all of our patients, we do maintain strict guidelines regarding payment plans. Failure to adhere to the payment schedule will result in revocation of the payment plan agreement

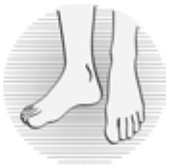
COLLECTIONS POLICY
Any account not paid within 90 days of the initial billing cycle will be referred to an outside collection agency, unless prior arrangements have been made. Patient agrees to pay all reasonable collection fees, including shares or commissions that will be assessed to us by our collection agency retained to pursue this matter, which will be as much as 25% of the principle balance owing. In order to refrain from raising our fees, we must control our costs and maintain efficiency in the business aspect of our practice. We are dedicated to providing you and your family with the best possible foot and ankle care available. We will also try our best to accommodate you whenever possible. If you have any questions, please contact our office and we will be happy to discuss them with you. Thank you for your understanding. We look forward to serving all your foot and ankle needs.

I have read this Financial Policy, understand and agree to its terms.

Name: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION/AUTHORIZATION TO PAY:
I hereby authorize Dr. Nazarian to release any information required in the course of my treatment. I hereby authorize payment directly to Dr. Nazarian for the surgical/medical treatment benefit. I understand that I am financially responsible for the charges not covered by my insurance. Per medicare requirements your progress notes will be available to you within 3 days of your visits. You may pick them up or you may request them to be mailed to you. I have received/been offered the notice of our privacy practices.

Name: _____ Date: _____



Sedona Foot & Ankle Specialists
Dr. Serj Nazarian, D.P.M
401 S. Calvary Way, Ste. A, Cottonwood, AZ 86326
928-282-3305

Patient Information

First Name: _____Middle Initial: _____ Last Name:_____

Nickname:_____ SSN# _____ Date Of Birth: _____ ☐ M ☐ F

Mailing Address:_____ Zip Code:_____

Phone (Home): _____ (Cell):_____ (Work): _____

Email: _____Emergency Contact Name: _____Phone:_____

Insurance Information

Primary:_____ Secondary: _____

Responsible Party/Main Policyholder Information

Name: _____ Relationship: _____

Date of Birth:_____ SSN#: _____

Who Referred You To This Office: _____

Chief Complaint:_____

Race: _____ Ethnicity:_____ Language: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐ Other: _____

Highest Level Education: _____ Student: ☐ Full Time ☐ Part Time ☐ None

Employment: ☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Other Driver Lic#: _____

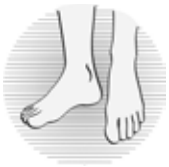
Primary Physician: _____ Pharmacy of Choice:_____

Authorization To Release Information/Authorization To Pay:
I hereby authorize Dr. Nazarian to release any information required in the course of my treatment i hereby authorize payment directly to Dr. Nazarian for the surgical/medical treatment benefit. I understand that I am financially responsible for the charges not covered by my insurance. Per medicare requirements your progress notes will be available to you within 3 days of your visits, you may pick them up or you may request them to be mailed to you.

Signed: _____ Date:_____

Signature below is only acknowledgment that you have received/been offered the notice of our privacy practices:

Signature: _____ Print name: _____ Date: _____



Sedona Foot & Ankle Specialists
Dr. Serj Nazarian, D.P.M
401 S. Calvary Way, Ste. A, Cottonwood, AZ 86326
928-282-3305

PATIENT NAME: _____ D.O.B: _____ DATE: _____

PRIMARY PHYSICIAN: _____ LAST VISIT: _____

MEDICATION ALLERGIES:
☐ NONE KNOWN ☐ PENNICILLIN ☐ CODEINE ☐ IODINE ☐ SULFA ☐ LOCAL ANESTHETICS
☐ OTHERS: _____

TAKING ANY FORM OF BLOOD THINNER:
☐ ASPIRIN ☐ COUMADIN ☐ PLAVIX ☐ OTHERS: _____

MEDICAL HISTORY: (PLEASE CHECK OF YOU HAVE):

☐ DIABETES	☐ MENTAL	☐ ARTHRITIS (TYPE)	☐ LUNG DISEASE	☐ HEART DISEASE
☐ BLEEDING	☐ NEUROLOGICAL	☐ LIVER DISEASE	☐ THYROID	☐ RENAL FUNCTION
☐ GOUT	☐ ULCER (STOMACH)	☐ HIGH BLOOD PRESSURE	☐ GI DISEASE	☐ HISTORY OF CANCER
☐ STROKE	☐ VASCULAR PROBLEMS			

☐ OTHER _____

CURRENT MEDICATION/DOSAGE:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

PAST SURGICAL HISTORY/YEAR

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

SOCIAL HISTORY:
OCCUPATION: _____ SMOKING: Y / N HOW MUCH: _____

DRINKING: Y / N HOW MUCH: _____

☐ WALK ☐ RUN ☐ HIKE ☐ PLAY SPORTS ☐ OTHER: _____

OFFICE USE ONLY

PAST PODIATRIC HISTORY

CONDITION: _____

TREATMENT: _____

CHIEF COMPLAINT: _____

PODIATRIC EXAMINATION

ONSET: SUDDEN/INSIDIOUS DURATION: _____

PREVIOUS TREATMENT: _____

_____

_____