FOREMOST PODIATRY

COMPREHENSIVE FOOT AND ANKLE CARE

GENERAL OFFICE POLICES:

1. Please notify us of any change in personal, medical or insurance information. We must have your updated insurance information prior to any appointment.
2. Payment is due at the time of service unless other arrangements have been made.
3. Accounts greater than 60 days past due are subject to additional collection fees.
4. Co-Payment is due the day of service. We will also collect fees for any services that will be applied to your insurance deductible.
5. $40 will be charged for missed appointments unless canceled at least 12 hours ahead. Two missed appointments in a row will result in being discharged from the practice.
6. Multiple missed appointments may result in discharge from the practice
7. $10 charge for paperwork related to disability, insurance claims or other forms.
8. $75 will be charged for cancelled or re-scheduled surgeries.
9. $25 will be charged if we receive incorrect information and need to re-submit insurance claims.
10. $40 will be charged for cancelled or returned checks.
11. If your insurance requires a referral or prior authorization we require the referral/authorization form prior to your appointment.
12. X-ray copies are available for $5 per sheet. CD's are $10.

Initials_____

ACKNOWLEDGEMENT OF RECEIPT of NOTICE OF PRIVACY PRACTICES:

I acknowledge that I will be provided a copy of the Notice of Privacy Practices and that I will read (or have the opportunity to read if I so choose) the Notice. The Notice of Privacy Practices is made available to the patient in every room.

Initials _____

INSURANCE ASSIGNMENT AND RELEASE

I agree to assign directly to Foremost Podiatry PC all insurance benefits, if any,otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance I authorize the use of my signature on all insurance submissions. The above named medical practice may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Initials _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to medical examination and treatment including performing any procedures or injections advised by the doctor, for my feet, ankles or legs.

Initials _____

I hereby agree to all of the above:

Print Name _____

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**