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. $100 will be charged for canceled 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 if we receive canceled or returned checks.
11. $15 will be charged to ship orthotics to home addresses at the request of the patient.
12. X-ray copies are available for $5 per sheet. CD's are $10.
13. $50 will be charged for missed or canceled testing appointments after authorization has been obtained and orders have been sent.

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 _____

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.

Initials _____

I hereby agree to all of the above:

Print Name _____

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

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Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services.

If my insurance requires a referral from my primary care physician than I am responsible to obtain the referral. If I am seen without this referral, than I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

If I am a VA patient, I understand that I am responsible for obtaining all authorizations prior to my appointment. I understand my appointment will be cancelled/rescheduled if I do not have a current authorization on file.

_____

Printed Patient Name (and Guardian Name if applicable)

_____ _____

Patient or Guardian Signature Date