Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to sign prior to any treatment.

All patients must complete our information packet and produce all insurance cards and id prior to seeing the doctor.

CUSTOM PRODUCTS (SHOES, INSERTS, ORTHOTICS, ETC.) ARE NON REFUNDABLE.

24 Hours notice is required in the event you cannot keep your appointment. If notice is not given in a timely manner. There is a mandatory $50.00 no show fee.

ALL returned checks have a $25.00 processing fee applied to the account.

Non insurance patients (self pay) **full payment is due at time of service**. We accept cash, check, credit, card, etc.

Regarding insurance

We may accept assignment of insurance benefits. **ALL co pays, coinsurance and deductibles are due at the time of service.** In the event that your insurance is not in network you will be considered self pay. **The balance is your responsibility whether your insurance company pays or not.** Your insurance policy is a contract between you and your insurance company. We are not a third party to that contract. Please be aware that some, perhaps all, of the services provided may be non covered services and not considered reasonable under your insurance program.

Usual and customary rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult patients

Adult patients are responsible for their portion of payment at the time of service depending of self pay or insurance coverage.

Minor patients

The accompanying parent or guardian is responsible for full payment. For non accompanying minors, non emergency treatment will be denied.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy. I understand and agree to this financial policy:

Signed Name: _____ Date: _____

Printed Name: _____

Notice of Privacy Act

Patient Contact

We may contact you to provide appointment reminders, treatment information, billing and payment information, or for patient satisfaction surveys.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Ocala Podiatry Corp 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 hereby authorize the doctor to release all information necessary to secure payment of my benefits. I authorize the use of this signature on all insurance claim submissions.

_____ (INITIALS)

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – such as ordering diagnostic test
- Payment – such as submitting information to your insurance company
- Health Care Operations – such as quality assurance review, coordination of care, eligibility verification.

In addition to the above, your medication information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and if we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances or we created or received the information in treatment.

You have the right to:

- Request a restriction on certain uses and disclosures; however we are not required to agree to any requested restrictions.
- Receive confidential communication from us, upon written request.
- Inspect and request copies of your medical information.
- Request to amend copies of your incorrect or incomplete medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice.
- Abiding by the terms of this notice.
- Providing written notice of any change to this notice. _____ (INITIALS)

Medicare and Insurance Authorization

I request that payment of authorized Medicare or insurance benefits be made to me on my behalf to Ocala Podiatry Corp for anyservice furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents; the information needed to determine these benefits or the benefits payable for any related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician, agency shown, or supplier agrees to accept the charge determination of the Medicare carrier as based upon the charge determination of the Medicare Carrier.

_____ (INITIALS)

Failure to Keep Scheduled Appointments

If you are unable to keep your scheduled appointment, we ask that you please notify our office; at least 24 hours prior to your appointment time. Should you fail to provide proper notice, you will be charged $50.00 for the time that was allotted to you. By not contacting our office to cancel or reschedule your appointment, those in need of a time slot are unfortunately unable to see us. Thank you for your cooperation. I have read the above policies and I understand and agree to these policies.

_____ (INITIALS)

Printed Name: _____

Signature: _____ Date: _____