

Comprehensive Foot Centers, PA – Treatment Agreement

PLEASE READ AND INITIAL EACH SPACE BELOW:

_____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

_____ For the purpose of payment, I allow Comprehensive Foot Centers, PA to release my Private Health Information to any and all of my insurance carriers, their third party payors, and claim reviewers until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information to or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ I acknowledge that I was provided a copy of the HIPPA Notice of Privacy Practices, that I have read (or had the opportunity to read if I so chose) and I understand the Notice.

Patient Financial Policy

_____ As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all personal (home address, phone numbers, employment, etc.) and/or insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

_____ **Your portion of payment for office services is due at the time of service.** We will accept VISA, MasterCard, Discover, cash, or check.

_____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits; you are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor will be responsible for payment of services. You are encouraged to contact our billing department with any questions.

_____ After insurance has paid us, you must pay any remaining balance within 30 days. If the balance is not paid within 30 days, you will be charged interest at the rate of 15.0% until the account is paid in full.

_____ Please honor our 24-hour reschedule notice as there IS a charge for appointments broken or cancelled without 24-hour's advance notice. Repetitive broken or cancelled appointments and/or non-compliance may result in the transfer of your care to an alternative practice.

_____ We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. Your upfront portion will be calculated based on your insurance benefits/limits and our negotiated fee agreement with your carrier. If you are seeing our doctor on an "Out of Network" basis, you will be subject to those out of network rates.

_____ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however you remain responsible for any charges to any service rendered. Patients are encouraged to contact their insurance plans for clarification of benefits prior to services rendered.

_____ If you possess more than one insurance plan, you **MUST** give our office staff a copy of all primary/secondary/tertiary insurance cards at the time of service. If a card is not available at the time of service, the patient will be required to pay for the services in full.

_____ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Any payment exceptions will be agreed upon in writing.

_____ PAST DUE accounts are subject to collection proceedings. All fees, including but not limited to collection fees, attorney fees, and court costs shall become your responsibility in addition to the balance due this office.

_____ Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the Comprehensive Foot Centers' doctor-patient relationship.

_____ There is a **service fee of \$25.00** for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will have to be either in cash or cashier's check.

Authorization of Payment

_____ I hereby assign all Medical Benefits directly to Comprehensive Foot Centers, PA for the payment of services rendered. I also author release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our staff.

Printed Name of Patient

Signature of Patient/Guardian

Date