Welcome to Our Office

FINANCIAL POLICIES

Thank you for choosing us as your Podiatric Physician. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

INSURANCE: If your Doctor is a participating provider with your insurance plan, we will submit your claims to your insurance company for any podiatry issues you are being treated for. To do this we must have complete and accurate insurance information and a copy of your identification card. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service. If you have an annual **deductible** which has not yet been paid in full then any charges incurred up to that amount are **due at the time of your visit.**

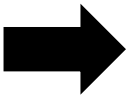
NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENTS: Payments for the balance due, co-payments, deductible, non-covered supplies, etc., are due at the time of service and may be made by cash, check or credit card (**Visa, MasterCard, Discover, AMX and Debit**). There will be a $35.00 charge for returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

REFERRALS: Some insurance companies require subscribers to have a referral from a primary care physician prior to being seen by a specialist. It is your responsibility to contact your PCP if a referral is needed, no services will be rendered until the referral has been received or the patient pays for the services at the time they are rendered.

NON-PAYMENT/PAST DUE ACCOUNTS: Please be aware that if a balance remains unpaid for 60 days, we may refer your account to a collection agency, and your account will be charged an additional $50 for all collections expenses and court costs. Partial payments are only accepted if negotiated in advance with the office manager.

MISSED APPOINTMENTS/NO SHOWS: In an effort to meet the demands for patient appointments, please call our office 24 hours in advance if you are unable to keep your scheduled appointment, this allow us to accommodate our other patients. It is our policy to charge a $25.00 fee for missed appointments not canceled within 24 hours prior to the scheduled appointment. We understand that 24 hour notice is not always possible and we will take these on a case by case basis. If you must miss an appointment, please call us as soon as you know you cannot make it. Patients who habitually do



not show and do not contact us take time away from other patients, and will be asked to find another provider. Our policy is to charge a fee of $150.00 when patients cancel surgery less than 2 weeks before the scheduled surgery date.

FORM COMPLETION: We reserve the right to charge a reasonable fee of $5.00 for form completion. i.e. Disability forms, Family medical leave forms etc.

ORTHOTICS: Orthotics is a non-covered service by most insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your orthotics benefits. A deposit of $100 is requested at the time of the examination and casting and full payment is due when orthotics are dispensed.

SUPPLIES: For your convenience, we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. These are non-covered items and we cannot bill insurance for these items. All retail items are final sale. No refunds will be given unless the product is defective, in this case an exchange will be made.

I, the undersigned, have read, understand and agree to the policies described above, and understand that Christopher Stewart, DPM, PC, The Podiatry Group will render services in consideration of and reliance on my authority to agree and my agreement to abide by the terms/guidelines above. I further understand and agree that a photocopy or facsimile of this agreement shall be as valid as the original and that any attempted modification of the above terms shall be void and without effort.

X_____ ____/____/_____

Patients Signature (or Legal Guardian) **Date**

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

In compliance with federal privacy law and regulations, all patients must, on their initial date of registration and thereafter upon request, sign and date this Written Acknowledgement From. If you would like a copy, we are happy to provide one at any time upon request.

I HEREBY ACKNOWLEDGE THAT I UNDERSTAND AND I CAN REQUEST A COPY, AT ANY TIME, OF THE PRIVACY POLICIES AND FULLY AGREE TO THE TERMS OF THE POLICY.

X_____ ____/____/_____

Patient Signature/Guardian **Date**