

*Please thoroughly read each East Ocean Podiatry policy, initial next to each policy and sign below:*

**Treatment Agreement**

\_\_\_\_\_ 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 **East Ocean Podiatry** to release my Private Health Information to any and all of my insurance carriers, their third 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 or contact any and all my treating physicians.

\_\_\_\_\_ I promise to provide complete and accurate information to the doctors about my health and medications, including over the counter products. I also understand my responsibility to be respectful of the doctors, staff and other patients.

**Acknowledgement of Receipt of Notice of Privacy Practices**

\_\_\_\_\_ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The HIPAA rights are also posted in the lobby and at [www.eastoceanpodiatry.com](http://www.eastoceanpodiatry.com).

**Patient Financial Policy**

\_\_\_\_\_ You must provide personal (address, phone numbers, etc) and/or insurance changes (carriers, networks, id numbers, etc.) to the office prior to your appointment.

\_\_\_\_\_ You are responsible for **all authorizations/referrals/precerts** needed to seek treatment with **East Ocean Podiatry’s** physicians.

\_\_\_\_\_ Your portion of payment for ALL office services is due **at the time of service**. We will accept VISA, MasterCard, 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. When you do 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 your designated patient account representative at our office with any questions.

\_\_\_\_\_ Please honor our 24 hours reschedule notice, as there may be a charge for appointments broken or cancelled without 24 hours advanced notice. Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice.

\_\_\_\_\_ We have made prior arrangements with insurers and other health plans to accept 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**. If you are seeing our doctors on a “Out of Network” basis, you will be subject to 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 all charges. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. **Patient are encouraged to contact their plans for clarification of benefits prior to services rendered.**

\_\_\_\_\_ Our office does not file secondary insurance, unless the patient has Medicare. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you MUST notify us of your **designated PRIMARY** policy.

\_\_\_\_\_ Pre-scheduled Surgical procedures require pre-payment/estimated deposit. **Your deductible/co-pay for this procedure is due at the pre-operative appointment.** For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility. There is a \$100.00 no refundable clerical fee for surgeries not cancelled two weeks in advance. We suggest you carefully select your surgical date to avoid this charge. It is your responsibility to obtain an adult to transport you to and from surgery and remain with you for 24 hours.

\_\_\_\_\_ PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees 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 **East Ocean Podiatry** relationship.

\_\_\_\_\_ There is a service fee of \$25.00 for all returned checks.

\_\_\_\_\_ ONLY UNWORN and NON-custom items are returnable within 5 days of receipt. Custom items such as orthotics are non-returnable.

**Authorization of Payment**

\_\_\_\_\_ I hereby assign all Medical benefits directly to **East Ocean Podiatry** for the payment of any services rendered. I also authorize 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 front office staff or supervisor. Suggestions and or grievances can be directed to the doctor via telephone, letter or email.

Patient’s Name \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Office Witness: \_\_\_\_\_ Date: \_\_\_\_\_ Patient initials to indicate copy received

My signature authorizes the assignment of benefits to **East Ocean Podiatry** and will remain on file until further written notification.