De La Sole Podiatric Medical Services LLC

Financial, Release of Records & Receipt of Privacy Policy Agreement and Acknowledgement

- **Insurance co-pays are due at the time of your appointment**. Your insurance policies may require you to make a copayment or pay a deductible for an office visit, a diagnostic test and/or a procedure; therefore payment is expected on the date of service.
- Our office accepts many health care plans. We will bill those plans with which we have an agreement and collect co-pays at the time of service. In the event that your insurer determines the service is "not covered" by the terms of your health care plan, you will be responsible for payment in full on the date of service(s) to include office visits and procedures.
- In the event that our physician(s) are not enrolled with your health care plan, you will be responsible for payment in full on the date of service(s). In this instance, you may submit your claim directly to your carrier to request reimbursement.
- In the event that your medical expenses will not be submitted to an insurance carrier, payment is due at the time of service to include office visits and procedures.
- **Many insurance companies require an authorization for visits to receive full benefit coverage**. If you are unsure if authorization is required, please call your insurance carrier directly. If required, the authorization must be received before your visit. Failure to provide us with the proper authorization may result in the rescheduling and/or cancellation of your appointment.
- Form fees are not covered by your insurance company. Therefore, there will be a $10.00 charge for each form. This is to be paid in advance.

Financial Agreement

- I hereby assume full responsibility for all charges incurred for professional services rendered by De La Sole Podiatric Medical Services LLC, and its assistants, including collection costs, unless the services are deemed "paid in full" as a result of a contractual agreement between De La Sole Podiatric Medical Services LLC and my insurer.

Authorization for the Release of Information

- I hereby authorize De La Sole Podiatric Medical Services LLC to release any medical information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

Group & Individual Insurance, Assignment of Benefits

- I authorize my health insurance benefit plan to pay directly to De La Sole Podiatric Medical Services LLC the medical and/or surgical, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to De La Sole Podiatric Medical Services LLC for charges not covered by this assignment.

Medicare, Claim Authorization and Payment Request

- I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts this assignment. Regulations pertaining to Medicare assignment of benefits apply.

- I acknowledge that I have read and agree to the financial policy of De La Sole Podiatric Medical Services LLC
- I acknowledge that I have read and agree to the privacy policy of De La Sole Podiatric Medical Services LLC

Acknowledgement of Receipt of Privacy Practices.

- I acknowledge that a copy of the Privacy Practice will be made available to me at my request, and that I have read (or had the opportunity to read if so chose) and understood the Notice.

Signature of Patient/Responsible Party:

_____

Print Name: _____ Date: _____ / _____ / ____