NORTH COAST PODIATRY

Joseph T. Breen, D.P.M.

3798 Janes Rd Suite #9
Arcata, CA 95521

Office: (707) 599-8677
Fax: (707) 599-8176

FINANCIAL POLICY

1. All copayments are due at the time of visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a violation of the contract you have with your insurance company. Our office accepts credit cards, debit cards, cash, and checks (post-dated checks are not accepted).

2. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility is calculated, you will be notified of the payment amount and due date.

3. You are ultimately responsible for payment of charges for services you receive from our office.

4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.

5. It is your responsibility to ensure that our physician is in your insurance network.

6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.

7. Payment is due for rendered services 10 days from receipt of your billing statement. Outstanding balances must be paid in full prior to any additional visit unless arrangements have been made with our billing department.

8. There is a service fee of $35 for *each* time a check is returned. The bank may return your check up to three times before considering it nonnegotiable. Your insurance company. Your insurance company does not cover this fee.

9. **A scheduled appointment means that time has been reserved for you.** Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery and in-office procedures must be received at least 5 days prior to the scheduled surgery date and time.

10. Patients who fail to keep or fail to cancel a scheduled appointment 24 hours in advance may be charged a $45 no-show fee. There is a $100 cancellation fee for scheduled surgeries or in-office procedures that are cancelled less than five business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.

11. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of California. Fees must be received prior to record delivery. No more than five pages may be faxed.

12. Administrative services: there is a $25 charge for *each* required administrative service, payable prior to service completion. This administrative service fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorization for brand or non-formulary drugs, letters for employers, schools, health clubs, and any other administrative items not covered by insurance.

13. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.

14. SELF-PAY: Payment in full is due at the time of service if you do not have health insurance coverage.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully. The privacy of your medical information is important to us.

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about privacy practices, our legal duties, and your rights concerning your protected health information.

We must follow the privacy practices that are described in this notice and we reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law.
You may request an additional copy of our notice (or subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and healthcare operations. Following are examples of the types of uses and disclosures of your protected health information that may occur:

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. We will also disclose protected health information to other physicians who may be treating you.

- **Payment:** Your protected health information will be used, as needed, to obtain payment information for your Healthcare Services. This may include certain activities that your health insurance plans may undertake before it approves or pays for the healthcare services we recommend for you.

- **Health Care Operations:** We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. We will share your protected health information with third party "business associates" that perform various activities for the business. When an arrangement such as this takes place, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information as necessary, to provide you with information about treatment alternatives or other health related services.

- **Uses and Disclosures Based on Your Written Authorization:** Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise submitted or required by law. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

- **Other Uses and Disclosures of Your Protected Health Information:** We may use and disclose your protected health information for purposes such as public health and safety, research, health oversight, abuse or neglect, Food and Drug Administration business, criminal activity, court or administrative proceedings, providing to others involved in your healthcare, or as required by law.

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NOTICE OF PATIENT RIGHTS

Access: You have the right to look at or receive copies of your protected health information. You must make a request in writing to the contact person listed herein to obtain access to your protected health information.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclose your protected health information, a description of the protected health information we disclosed, the reason for that disclosure, and certain other information.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in cases of an emergency.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing and we must accommodate your request if it is reasonable.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons, and we would do so by providing you with a written explanation. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities that you name, of the amendment.

Questions and Complaints

If you want more information about our privacy practices or if you have any questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights or you disagree with a decision we made about access to your protected health information, you may file a complaint with us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. Contact information for the U.S. Department of Health and Human Services will be provided upon request.

We support your right to protect the privacy of your protected health information.

Contact: North Coast Podiatry
Attn: Privacy Coordinator
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