

Indiana Podiatry Group Financial Policy and Patient Consent Form

Financial Policy

I understand payment is expected at the time of service. Accepted are MASTERCARD, VISA, AMERICAN EXPRESS, CASH, or CHECK.

I understand there will be a charge of \$25.00 for any returned checks.

I understand a charge will be made for no show appointments or cancellations with less than 24 hours notice.

I understand that I am responsible for any co-payments, deductibles, non-covered services, or supplies at the time services are rendered.

I understand that as a courtesy to me, my medical services will be filed with my insurance carrier or I will be provided with the information needed to file a claim myself. I am strongly encouraged to contact my insurance company if I have not received an explanation of benefits within 30 days. After 30 days I will be responsible for any unpaid balance on my account.

I understand it is my responsibility to know what my insurance requirements are.

I understand that it is my responsibility to provide Indiana Podiatry Group, Inc. with the following as is required by my insurance:

- 1) Referral from a primary care physician
- 2) Prior authorization or pre-certification
- 3) Paperwork my insurance requires to be attached to any claim filed on my behalf

I understand that I am liable for any services denied by my insurance carrier for lack of any of the documents listed above.

I understand that any charges not covered by my insurance carrier will be my responsibility.

If insurance benefits are mailed to me, I agree to forward them directly to Indiana Podiatry Group, Inc., along with the Explanation of Benefits.

If payment is not made after reasonable notice of any balance due on my account, I will be responsible for all collection effort fees, including attorney and court costs.

X _____

Patient / Parent / Guardian / Advocate Signature

X _____

Date Signed

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do we are bound by this agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

X _____

Patient / Parent / Guardian / Advocate Signature

X _____

Date Signed