NEXT STEP
foot & ankle clinic

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www.NextStepFoot.com

FINANCIAL & PRIVACY POLICY AGREEMENT

A Word About Appointments

Your time is valuable, and we strive to keep as close to your scheduled appointment time as possible. As with any medical setting, situations may occur that keep the doctor from seeing you at the scheduled time. If we are running late, we will inform you and give you the option to waiting, or rescheduling.

Please call us if you are running late to see if accommodations can be made. If you are more than **15 minutes late,** we may ask you to reschedule your appointment.

If you know you are going to miss your appointment, kindly let us know. **A $25 fee will be assessed for no-shows.**

Please read and initial your consent to the following:

X-Rays and photos of your feet may be taken during your visit. X-Rays or photos of individual feet or portions of feet may be used for medical records to document wound healing, for educational or marketing purposes. If used for educational or marketing purposes, your identity will be kept confidential. _____

E-Prescribing. We participate in the government mandated practice of E-Prescribing, which means we electronically submit prescription requests to your choice of pharmacy. This process checks for potential adverse reactions by creating a history of medications prescribed. _____

Electronic Communication. With your provided email address, we will subscribe you to our Patient Portal. The Patient Portal will provide a secure method of communication between our clinic and you.

(Patient Portal account information is mentioned later in this consent form) _____

Financial and Privacy Policy

Thank you for choosing our office to provide your foot and ankle care. We strive to make our payment policy as clear as possible for our patients. The medical services provided by our offices are services you

have elected to receive, which implies a financial responsibility on your part.

INSURANCE: Next Step Foot & Ankle Clinic (NSFAC) does not participate in all insurance networks; our in-network list is available on our website. Claims will be submitted electronically to your insurance provider. It is our policy to verify your insurance benefits to give our best estimate of what your portion will be. **We will collect payment for co-pays, unmet deductibles, co-insurances and balances that apply at the time of service.** Your insurance company may need you to supply certain information to them directly. It is your responsibility to get this information to them in a timely manner. Claim balances become patient responsibility if insurance requests are ignored. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays on your claim. Your insurance benefit is a contract between you and your insurance company.

MEDICARE: We are a participating Medicare provider. We will bill Medicare and any secondary policy. However, that does not mean that all services are covered. Non-covered services will be identified as such, and you will have the choice to receive or not receive these services. You are responsible for paying your annual Medicare deductible. You are also responsible for any co-insurance, which is 20% of the Medicare allowed amount for an item or service. **We do not participate in all Medicare replacement plans.**

SECONDARY & TERTIARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment or explanation of benefits (EOB) is received from your primary insurance. We do not bill your tertiary insurance.

SELF-PAY: Payment in full is due at the time of service if you do not have health insurance, and for items not covered by insurance. We accept cash, money orders, check, Visa, MasterCard, Discover and Care Credit. **A $35 fee will be assessed for all bad checks.**

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or may not be considered reasonable/customary/necessary by Medicare or other insurers. You are responsible for payment for those services.

REFERRALS / AUTHORIZATIONS: We do not require a referral t be seen **UNLESS** required by your insurance plan. If you arrive for an appointment and the necessary referral or authorization is not in place, you will be given the option to reschedule or pay for those services at the time they are given. We will do all that we can to help you get these in place, by ultimately it is your responsibility to understand your plan's referral/authorization requirements. NSFAC may refer patients to other providers, facilities and labs. We are not responsible for these entities. The patient should contact these outside service providers, facilities or labs directly regarding any billing questions.

BILLING: Patients will be sent statements at the end of the month, showing any charges, payments you have made, what your insurance company has paid on your behalf, any amounts that we have adjusted off due to our contract with your insurance company and what your remaining financial responsibility is.

Please contact our billing office immediately upon discovering any error or if you are unable to make payment. We realize temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in managing your account. Payment arrangements will be agreed upon in writing. The third billing statement for all patients is considered **Final Notice**, and if no payment is received on your account, you will receive a letter requesting immediate payment and/or asked to set up a payment plan with us. A **re-billing charge of $25.00 per month** will be assessed on all accounts after the second statement. Please be aware that if a balance remains unpaid after the fourth billing statement, we may refer your account to collections and/or small claims court and you may be discharged from this practice.

In case of defaulted Payment Plan Contracts, you agree to pay any fees and costs incurred while collecting the balance on the amount owed. If this is to occur, you will be notified by regular and certified mail that you have 30-days to find alternative podiatry care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

REFUNDS / RETURNS: Only unworn and non-custom items **are returnable within 14-days of receipt**, if NO visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable. NSFAC issues patient refunds in the original tender within **30-days** of a completed investigation of the potential over-payment, as long as other outstanding accounts are resolved.

MISSED APPOINTMENTS: A **$25.00 fee** will apply for appointments broken or cancelled without **24 hours advanced notice**.

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Assignment of Benefits

I, the undersigned patient or authorized representative, certify that I have coverage as presented, and assign directly to DJ Silvester, DPM PA / Next Step Foot & Ankle Clinic all insurance benefits payable to me for services rendered. I understand that I am liable for payment of deductibles, co-payments, and/or non-covered services. I authorize the release of medical information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of my signature on all submissions.

I understand that it is my responsibility to notify the doctor's office if there is any change to my insurance coverage.

I have read the above policy regarding My Financial Responsibility to Next Step Foot & Ankle Clinic / DJ Silvester, DPM PA for medical services and products provided. I agree to pay Next Step Foot & Ankle Clinic / DJ Silvester, DPM PA any balance unpaid by my insurance carrier for myself or the patient named below.

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Patient Acknowledgement of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to read a copy of Notice of Privacy Practices. This Notice of Privacy Practices is available in our office, and on our website: www.nextstepfoot.com. Protected Health Information (PHI) may consist of items such as diagnoses, treatments, labs, prescriptions and appointments.

Who may we discuss your Protected Health Information (PHI) with?

☐ Spouse Name: _____ Contact Number: _____

☐ Child Name: _____ Contact Number: _____

☐ Other: _____ Name: _____ Contact Number: _____

_____

Date: _____

If Legal Authorized Representative, what is your relationship to the patient? _____

I, the undersigned patient or authorized representative acknowledge and consent to the aforementioned Next Step Foot & Ankle Clinic's Financial and Privacy Policy Agreement.

Patient or Legal Authorized Representative Full Name Full Name	Patient or Legal Authorized Representative Full Name Signature	Date