Mercer-Ocean Podiatry, PC

Dr. Frank Killian, DPM, FACFAS *Dr. Sameep Chandrani, DPM, AACFAS*

FINANCIAL POLICIES & CONSENTS

1. **Insurance Assignment and Release Authorization**

I, the undersigned, have health insurance coverage (please enter name of your insurance) _____ and assign directly to Mercer - Ocean Podiatry, P.C. all medical benefits. I authorize the use of this signature on all my insurance submissions and authorizations. If any, otherwise payable to me for services rendered to me or my dependents. I hereby authorize the doctor and his staff to release all information necessary to secure the payment of benefits.

2. Coinsurance, Copayments, Deductibles, Noncovered Services and Supplies

Copayments, noncovered services and supplies are due at the same time of service. We accept all types of payments (cards, checks, cash). All payments are due at the time of your appointment. Balances over 30 days are subject to monthly service charge. Balances over 60 days from time of service are considered delinquent and will be turned over to an outside collections service. I understand that my insurance carrier may exclude/disallow coverage for certain services, treatment, medication, appliances, orthotics, or other durable medical equipment that the physician may prescribe or recommend, and that I will be financially responsible for these noncovered charges. Furthermore, I understand that I cannot return such items for a refund because such items are considered single patient use only.

Our office may charge a $15.00 fee for all forms completed by our staff. There will be a 5-7 day turn around time for the completion of these forms

3. Uninsured Patients

Payment in FULL is required at the time services are rendered and supplies dispensed.

4. Referral Authorization

Your insurance carrier may require authorization from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referral authorizations prior to your visit. Contact your insurance carrier if you have questions in regards to this issue.

5. Appointment Cancellations

Please give our office a 24-hour notice if your appointment needs to be cancelled or rescheduled to avoid a $25.00 no-show fee.

6. Assignment of Rights and Benefits

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case. I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

7. DMV Handicap Parking Application, Medical Records

There is a $10.00 fee for ALL DMV handicap parking application.
ATTORNEYS ONLY: For medical records, an initial $10.00 search fee is placed, with an additional $1.00 per page. (P.L. 1971, c. 136 (C.26:2H-1))

8. Surgery Cancellation Fee:

Any surgeries cancelled within 14 business days of the scheduled surgery will incur a $250.00 fee, surgeries cancelled 72 hours prior to scheduled surgery will incur a $500.00 fee. (Fee will be waved if cancellation is due to a death in the family, illness, or if the patient is not cleared for surgery)

9. Returned Checks

Any returned check from a bank for non – payment (insufficient funds) shall result in the patient's account being assessed a $40.00 fee per check.

By subscribing my name below, I acknowledge my understanding and agreement of all above terms and conditions.

Patient/Guarantor Signature: _____

Patient Name: _____

Date: ____ / ____ / _____