#

PATIENT AGREEMENT

Patient Financial Agreement:

Insurance Benefits/Copayment, Deductibles and Coinsurance: Please be advised that your insurance policy is a contract between you and your insurance company. If you have any questions regarding your plan benefits or coverage please contact your insurance carrier directly.

Claims will be filed with your insurance company as a courtesy. Patients are required to make copayments and payment for non-covered services/products at the time services/products are rendered. Office visits may be billed in conjunction with a self-pay service. If you have any deductibles or coinsurance amounts to be met after claims have been processed by your insurance, your balance will be sent to you in a patient statement. Balances are due 30 days from the receipt of the statement. All patient refunds and/or patient credit balances will be applied to any existing owed balances before issuing a refund to the patient.

Failure to pay the balance by the second billing statement may result in your account being turned over to collections.

Self-Pay Policy:

Patients who are self-pay will be required to make payments at the time services are rendered. For your convenience we offer several payment options including cash, check, and credit card. For those who qualify we also offer 3rd party financing through Care Credit.

HMO Patients:

Most HMO insurance plans require patients to obtain a referral prior to services being rendered. Please be sure to have a referral prior to your scheduled appointment. Patients will be held financially responsible for all charges incurred for services rendered and not covered due to no referral on file.

Workers Compensation/ Auto Accident Claims:

* For worker compensation claims authorization must be obtained prior to treating the worker compensation injury. Claims for work related injuries will be sent to the insurance company or your employer. The patient is responsible for the balance due for services rendered if not covered by insurance or employer.
* Auto Accident Claims: Central Massachusetts Podiatry does not do direct billing for auto insurance claims. Nor do we hold account balances for settlements involving auto accidents. Patients are responsible to pay for all charges incurred at the time services are rendered.

Routine Foot Care:

Insurances generally exclude routine foot care services (nail and callus care) from coverage. There are however exceptions and specific indications under which there are program benefits. Patients will be held financially responsible for those charges not covered by insurance.

Returned Checks:

All returned checks will be subject to a $35.00 returned check fee plus the original amount of the check. Default accounts may be turned over to collections.

Return Policy:

All returns must get approval from management before a refund can be issued. Returns are only accepted within 30 days from purchase. Returns must be unused, in new condition, and in original packaging.

Appointment Scheduling:

Our office values your business and believes it is important to set aside the proper amount of time to establish the patient/doctor relationship at your first visit. We dedicate an extended period of time for this visit, and therefore ask you to confirm this appointment at least 48 hours before. It would be best to have 2 ways to contact you for this confirmation and thus limit the chance of a missed appointment. If we are unable to confirm 48 hours prior to this appointment, the appointment will be cancelled and offered to a patient off of our waiting list. If the appointment is confirmed but you fail to show up for the visit, a $100 fee will be charged. All other appointments require 24 hours’ notice to cancel or reschedule. No shows or appointments rescheduled with less than 24 hours’ notice could result in a missed appointment fee of $35. We appreciate your compliance.

# Promissory Note Agreement:

# All payments due under this agreement shall be made at Central Massachusetts Podiatry, by phone with charge to your credit card or by mail at 299 Lincoln Street, Suite 202, Worcester, MA 01605, unless you are notified otherwise in writing by Central Massachusetts Podiatry.

# In the event that the borrower's payment is returned by the bank or credit card company, the returned payment amount plus a $35 fee will be due immediately and does not relieve the borrower of the current monthly, weekly, or bi-weekly obligation. This payment will be required in cash or certified funds (money order or cashiers check). Subsequent payments may be required to be remitted by certified funds at the discretion of Central Massachusetts Podiatry.

# In the event of default, the borrower agrees to pay all costs and expenses incurred by Central Massachusetts Podiatry, including all reasonable attorney fees (including both hourly and contingent attorney fees as permitted by law) for the collection of this Agreement upon default, and including reasonable collection charges (including, where consistent with industry practices, a collection charge set as a percentage of the outstanding balance of this Agreement) should collection be referred to a collection agency. Additionally, collection agency action will result in the patient being discharged from further medical care at this practice.

# No modification or waiver of any of the terms of this Agreement shall be allowed unless by written agreement signed by both parties. In the event that any portion of this Agreement is deemed unenforceable, all other provisions of this Agreement shall remain in full force and effect.

# With my signature below, I hereby agree to all terms and conditions set forth in this Agreement.

# \*The current balance refers to the balance owed by the patient on the date of this signed Agreement. The patient's balance may increase after all insurance claims have been processed and copays, co-insurances or deductibles are applied. In this event, the borrower must contact Central Massachusetts Podiatry for a new Promissory Note Agreement to be executed if payment arrangements are necessary.

# Consent to Call:

# Entry of any telephone number constitutes written consent for our practice to send automated, prerecorded, and artificial voice telephone calls to that telephone number. To alter or revoke this consent, visit the Patient Portal "Contact Preferences" page.

# Medication History Download:

# I understand and I give my consent to retrieve and review my medication history. I understand that this will become part of my medical record. A medication History is a list of medicines that these providers and other healthcare providers have recently prescribed for a patient. It is collected from a variety of sources, including, a patient’s pharmacy, health plans, and other healthcare providers.

**MEDICARE DMEPOS SUPPLIER STANDARDS**

Medicare regulations have defined standards that a supplier must meet to receive and maintain a supplier number. The supplier must certify in its application for billing privileges that it meets and will continue to meet the standards. The supplier standards in full can be found in [42 CFR Section 424.57©](http://www.ecfr.gov/cgi-bin/text-idx?SID=212c71702b0049d61bb25253ed6ec5e8&node=42:3.0.1.1.11&rgn=div5#42:3.0.1.1.11.4.5.8). The following is an abbreviated version of the supplier standards as provided on the CMS-855S form:

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual whose signature is binding sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. A supplier cannot contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier’s compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier’s place of business and all customers and employees of the supplier. If the supplier manufactures its own items this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57(c)(11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its’ Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. A supplier must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. A supplier must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. A supplier must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57(d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act), physical and occupational therapists or DMEPOS suppliers working with custom made orthotics and prosthetics.

 Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, you acknowledge that you have received our Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Patient or Guardian Name Date

Patient or Guardian Signature