FINANCIAL AGREEMENTS AND NOTICE OF PRIVACY PRACTICES

-We will gladly accept monthly payments.
-Patients who will pay off their entire balance within 30 days after insurance has paid will be eligible for a 15% discount.
-Any accounts which are not paid as agreed will be turned over to our collections department for further action.
-We accept cash or checks, Visa, MasterCard, Discover, and American Express.
-Your insurance is a contract between you, your employer and the insurance company.
We are not a party to that contract. It is your responsibility to contact your insurance with any questions.

Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. For example; Orthotics are not usually covered by most insurance companies including Medicare. Non-covered services are the patient's responsibility. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We are here to help you.

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Pocatello Podiatry and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient/Parent Signature ________________________________ Date___________________

Print Name ___________________________________

MEDICARE SIGNATURE ON FILE

(Only sign this portion if you have Medicare)

I request that payment of authorized Medicare benefits be made on my behalf to Pocatello Podiatry for any services furnished me by the listed physician/supplier. I authorize any holder of my medical information to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap Insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

Patient Signature______________________________________ Date____________________________________

Print Name____