Madison Advanced Foot & Ankle

OFFICE POLICIES

SCHEDULING APPOINTMENTS

Every effort is made to keep your waiting time to a minimum. We request that you arrive 15 minutes before your scheduled appointment time. ALWAYS bring a valid I.D. and your current insurance cards to obtain services. Please bring with you a list of all prescribed and over-the-counter medications you are presently taking to each office visit. Patients who arrive more than 15 minutes late for appointments may have to be rescheduled. For AUTO and WORKMAN'S COMPENSATION APPOINTMENTS, we must have all required information before you are seen by the doctor.

SAME DAY APPOINTMENTS

If you have a medical problem that you believe requires a "same day" appointment, *please call the office as early as possible during office hours to schedule an appointment with your physician.*

CANCELLATION POLICY

Kindly give 24 hours' notice if you are unable to keep your appointment. *If you do not cancel 24 hours prior to your appointment or are a "no show", you may be subject to a $35.00 "no show" fee.* This fee is not the responsibility of your insurance company and they will not be billed.

REFERRALS FOR SPECIALITY CARE

If your insurance company requires that you obtain a referral from a primary care physician (your PCP) prior to seeing a specialist, they also require your primary care physician to conduct a medical evaluation of your medical problem and your need for specialty care. Therefore, if you believe you need to see a specialist, we ask that you make an appointment with your primary care physician in order that he or she may evaluate the problem and make a determination of need for, and nature of, the specialty referral.

SPECIAL FORMS OR LETTER REQUEST

There is a $35.00 charge for clinical medical notes, imaging, or letters of any kind to be completed by our practice. Please allow 10 days.

AFTER HOURS *If you have a life threatening emergency, call 911, or go to the nearest emergency room.

PAYMENT

Payment will be requested at the time of service for all services which are not covered or determined to be the patient's responsibility, including self-pay (no insurance), co-payments, deductibles and co-insurance depending on your coverage. *We will kindly reschedule your appointment if you are unable to pay at the time of services are rendered.* Methods of payment include cash, debit, MasterCard, Visa, Discover Card, and American Express. We also accept personal checks. If a check should bounce for non-sufficient funds, there will be a $25.00 charge to the patient.

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FINANCIAL POLICY

Madison Advanced Foot & Ankle participates with most major insurance carriers. Please consult the provider list for in-network savings with your insurance company. *It is imperative that the office has your correct insurance information on file at all times. It is ultimately your responsibility to know the benefits provided under your insurance plan.* As a courtesy to our patients, we file insurance claims for those insurances with which we participate. Accounts with outstanding balances greater than 90 days will be considered in collection status. All costs associated with sending the patient to collections will be the responsibility of the Guarantor. Payment plans can be arranged by speaking with the front desk.

PRESCRIPTION REFILLS

Please call your pharmacy regarding refills on medications at least 72 hours in advance to allow sufficient time for the pharmacy, and your physician, to receive and respond to your request before you run out of your medication. **For maintenance medications, your healthcare provider will prescribe enough refills to last until your next office visit. If you are out of refills, this is an indication of the need to schedule a follow-up appointment with your physician. YOU MUST HAVE A VALID I.D. TO OBTAIN SERVICES.**

Madison Advanced Foot & Ankle

ASSIGNMENT OF INSURANCE BENEFITS
Medicare, Supplemental and Commercial Insurance

If applicable, I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services ("CMS") and its agents and/or any supplemental insurance companies any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to **Madison Advanced Foot & Ankle** ("The Practice") on my behalf for any services furnished me by or in The Practice, including physician services. I authorize The Practice to act as my agent to help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, The Practice may prescribe testing procedures to be performed here. I understand, and have been advised that, according to Wisconsin Law, I am under no obligation to use this facility. ***I understand that I am responsible for full payment of any charges, including non-covered services, deductibles, and/or co-payments due.*** Regarding Commercial Insurance if applicable, I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. **Madison Advanced Foot & Ankle** request that payment of authorized benefits be made on my behalf to ("The Practice") for any services provided by The Practice physicians. ***I understand that I am responsible for full payment of any charges, including non-covered services, deductibles, and/or co-payments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. It is my responsibility to ensure that an authorization is on file with The Practice prior to having my procedure performed. When applicable, I understand that I am RESPONSIBLE for full payment of all charges in the absence of an authorization.***

Madison Advanced Foot & Ankle

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Madison Advanced Foot & Ankle ("The Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Practice. I understand that diagnosis or treatment of me by The Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of The Practice. The Practice is not required to agree to the restrictions that I may request. However, if The Practice agrees to a restriction that I request, the restriction is binding on The Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that The Practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review The Practice's Notice of Privacy Practices prior to signing this document. The Practice's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of The Practice. The Notice of Privacy Practices for The Practice is also provided in our waiting room. This Notice of Privacy Practices also describes my rights and The Practice's duties with respect to my protected health information.

The Practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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SIGNATURE OF PATIENT/PARENT OR LEGAL GUARDIAN **DATE**