BRANDYWINE FAMILY FOOT CARE / FOOT & ANKLE ASSOCIATES

Podiatric Medicine and Surgery
Dr. Vincent J. Pongia, Jr.
Dr. Kevin J. DeAngelis
Dr. James A. Cancilleri

Office Policy

Welcome and thank you for the opportunity to provide you with our medical service. We want to make your visit here as pleasant and comfortable as possible. To better serve you, we have prepared the following summary of our office policies.

Please take a few minutes to read the following information and sign this form where indicated.

Financial Concerns

In general this office participates in most insurance plans as well as a limited number of managed health care plans and health maintenance organizations (HMO's). Medical services are to be paid for at the time service is rendered unless other arrangements are made in advance. Our billing service will submit covered services to those insurance companies in which we participate.

HMO Plans

The following guidelines apply for patients enrolled in health maintenance organizations (HMO's) that require referrals prior to office services:

All HMO patients are responsible to have a valid referral for the date of service on which they are being treated.

In accordance with HMO guidelines, anyone without a referral will be held financially responsible for that service. Please be aware that it is not the responsibility of this office to inform patients as to the intricacies of how their insurance programs work. As the patient, it is your responsibility to keep track of and secure your referrals.

In accordance with HMO guidelines, NO PATIENTS WILL BE SEEN WITHOUT A REFERRAL unless arrangements have been made in advance to satisfy the financial obligation for the services rendered.

Co-Payments

All co-payments (co-pays) must be paid *at the time of service*. No service will be rendered until the office co-pay has been satisfied. A $10.00 process fee will be assessed if it is necessary for the office to bill for co-payments.

Missed Appointment: PLEASE READ THIS CAREFULLY!!!!

Please be aware that this office is a very busy office. Appointments are frequently made weeks in advance for patients. It is expected that the patient either keeps their appointment or notifies the office of cancellation at least 24 hours in advance. There is a $45.00 fee for missed appointments or appointments cancelled with less than 24 hours notice. This policy applies to all patients, including those with HMO contracts.

Please understand that the purpose of this policy is not for the financial gain of the office. We have established this policy in order to provide maximum opportunity for all patients to gain access to this office.

Surgical Scheduling

There are many patients who require scheduling of either office or operating room surgery as part of their overall treatment. When patients schedule surgery, this office must set aside large blocks of time throughout the week to accommodate the surgical needs of our practice. To avoid wasting this surgical time, it is imperative that we establish guidelines for cancellation of operative procedures.

As such, it is expected that any surgical patient notify this office at least 3 days prior to their scheduled surgical time if they wish to reschedule their surgery time, their surgery date or to cancel their surgery. Failure to do this will result in a $350.00 charge that must be satisfied by the patient regardless of insurance coverage.

Billing Office

In the event that you should receive a bill from BRANDYWINE FAMILY FOOT CARE / FOOT & ANKLE ASSOCIATES and have questions pertaining to the bill, PLEASE DO NOT CALL THE OFFICE as we have limited access to your billing information. All questions regarding billing should be directed to the PMA Billing Office at 610-917-9281. Please be advised that your billing question will be handled in a timely manner.

We are committed to providing you with the very best podiatric medical and surgical services available. We maintain 24 hour coverage and can be contacted either here in the office or through our answering service. It is our pleasure to be of service to you.

Please check the box below:

Σ I acknowledge that I have read, understand and accept the above office policies.

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PRINTED NAME of Patient, Parent (if under 18), Guardian or Personal Representative

RELATIONSHIP TO PATIENT (*Circle One*): Self Parent Guardian Personal Representative

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SIGNATURE of Patient, Parent (if under 18), Guardian or Personal Representative DATE