# Manhattan Footcare's Office Policies

1. If you need to reschedule, call within **24 HOURS** of scheduled appointment in order to avoid an in-office **$25.00** non-cancellation fee.

2. All insurance **CO-PAYS** and applicable **DEDUCTIBLES** are due at the time of the visit.

3. No charges are allowed unless the charge is $50.00 or more.

4. **IT IS THE PATIENT'S RESPONSIBILITY** to update any insurance or changes in your contact information with our staff in order to avoid any out of pocket expense.

5. Upon arrival you **MUST** sign in to keep your appointment time.

6. If your insurance policy requires a referral to see a specialist, please have it at the time of the visit.

7. Should you receive payment from the insurance company for the doctor, timely reimbursement for your care is imperative.

8. If you are a diabetic please make sure to provide your primary care physician's name and contact information

**I HAVE ACKNOWLEDGED AND AGREE TO FOLLOW THE POLICIES OF THIS OFFICE.**

**Print:**________________**Signature:**____________________**Date:**___________

**Thank you and enjoy your visit with our Doctor ☺**

anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friend who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend you protected health information.** If we deny your request amendment, you have the right to file a statement of disagreement with us and we pay prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserved ther right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003

---

We are required by law to maintain the privacy, individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

**Print Name:**________________________ **Signature:**______________________ **Date:** _________

**---PLEASE TURN OVER PAGE---**

## Manhattan Footcare Out of Network Financial Policy

We accept assignment on most insurance benefit plans. However, on certain occasions your insurance company may send the check directly to you. In such an event, please sign the back of the check and immediately bring it to the office where you were seen. Should you not do so, you will become liable for the entire amount billed to your insurance carrier.

Thank you for understanding our Out of Network Financial Policy. Should you have any questions regarding this policy, please feel free to discuss it with us at any time.

I have read the Out of Network Financial Policy and understand and agree to this policy.

**Print**_______________________ **Signature**_______________________ **Date**__________

# How did you HEAR about us?

We try our very best to let the public know where we are and how we could help! Please indicate how we reached you!

Did you find us on the Internet? Where?

___Google
___Insurance Websites
___ ZocDoc.com
___ CitiSearch.com
___ ManhattanFootcare.com
___ other: ______________________

Word of Mouth Referral? If so, by Whom? ________________________________________

Did you walk by us? If so, by what location? _____________________________________

Did you run into any of our advertisements? _____ If so, where did u see our advertisement?
______________________________________________________________________________

Thank you for your feedback ☺ it is greatly appreciated!

## Attention!

We need to know what doctors you see, please list your Primary Physician's name, contact information and when last seen below: If you are a diabetic this information is required.

Name: _________________________________
Phone#: _______________________________
Last Visit: _____________________________

Have you ever been to a Podiatrist before?

Name: _________________________________
Phone #: _______________________________
Last Visit: _____________________________
Reason: _______________________________