



A Foot Above Podiatry Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

I. This is a formal notification, as required by the government concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including medical records, conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as .PHI. or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about release of information. **You can change this information at any time with either written notification or verbal notification, followed up in writing.** Changes can only impact the care or information from that point in time forward.

II. Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations while under our immediate care, for your care needs. This may include any foot care evaluation and exam, procedures done related to your needs, medication management, physical therapy, referral for services, diagnostic tests or treatment related to this care. Release of information to family and significant other (husband or wife) can be done only with your permission on this form.
- For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes, pictures and procedure notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on this registration form.
- Disclosure to your family and friends concerning any related health care information identified on this registration form, which can be modified at any time orally, followed by written consent
- Consent is not required for emergency care and treatment An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.**

Certain disclosures can be made without your consent and they are as follows:

- Disclosure required by the government or law enforcement agencies. An example would be victims of abuse
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.
- For worker's compensation cases or employment related assessments

III. Your rights for your health information include: The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI, but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to collect your file through an amendment process if appropriate.

IV. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice.

An updated Privacy Notice will be posted in the office within 60 days of the revision.

V. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Practice Administrator at our Business office to resolve your concerns or you may contact the Office of Civil Rights

Patient Signature: _____ Date: _____

Authorized individual to release medical information about you:

Name: _____ Relationship: _____



Financial Policy

Thank you for choosing A Foot Above Podiatry to provide you with medical care. We are committed to serving you with skill and high quality care at the lowest possible cost. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. The following is a statement of our financial policy which we require you to read and sign.

We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

If you are a member of a managed care plan with which A Foot Above Podiatry participates, your co-payment is expected at the time services are rendered. We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services provided, unless your referral is presented at your visit. If you do not have a referral from your primary care physician at the time of visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not been met. You are also responsible for any coinsurance which is usually 20% of the allowed amount for an item or service.

Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. Please note orthotics will not be submitted to your insurance company. Payment of \$300 will be due upfront prior to being casted for orthotics. An itemized receipt will be given to you to submit to your insurance company if it is a covered benefit.

Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check, VISA/Mastercard, AMEX, Discover. An additional \$15.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

I _____ have read, understand and agree to the terms of the above Financial Policy of A Foot Above Podiatry.

Signature _____ Date _____

Revised 4/1/2010