Please thoroughly read each SAPC policy, initial next to each policy and sign below:

Treatment Agreement

____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

____ For the purpose of payment, I allow ***S&A Podiatry Clinic, Inc.*** to release my Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The SAPC HIPAA rights are also posted in lobby and at www.sapodclinic.com.

Patient Financial Policy

____ You must provide personal (address, phone numbers, etc) and/or insurance changes (carriers, networks, id numbers, etc) to the office at least 2 days prior to your appointment. In the event the office is not informed, you will be responsible for any charges denied.

____ You are responsible for all authorizations/referrals/precerts needed to seek treatment with SAPC physicians.

____ Your portion of payment for ALL office services is due **at the time of service**. We will accept VISA, MasterCard, American Express, cash or check.

____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.

____ Please honor our 24 reschedule notice, as there may be a charge for appointments broken or cancelled without 24 hours advanced notice. Repetitive broken or cancelled appoints and/or non-compliance may result in transfer of your care to an alternative practice.

____ We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. Your upfront portion will be calculated based on your insurance benefit/limits and our negotiated fee agreement with your carrier. If you are seeing our doctors on an 'Out of Network" basis, you will be subject to out of network rates.

____ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

____ Our office does not file to secondary insurance, unless the patient has Medicare. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you MUST notify us of your designated PRIMARY policy.

____ Pre-scheduled Surgical procedures require pre-payment/estimated deposit. Your deductible/co-insurance/co-pay for this procedure is due at the pre-operative appointment. For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

____ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account.

____ PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

____ Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the S&A Podiatry Clinic's Doctor-Patient relationship.

____ There is a service fee of $25.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of "Theft-by-Check" will be requested from the District Attorney's Office.

____ SAPC issues patient refund checks within 90 days of a completed investigation of the potential overpayment.

____ ONLY UNWORN and NON-custom items are returnable within 3 days of receipt. Custom items are non-returnable.

Authorization of Payment

____ I hereby assign all Medical benefits directly to ***S&A Podiatry Clinic*** for the payment of any services rendered. I also authorized release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

Patient's Name: _____ Signature of Patient/Guardian: _____ Date: _____

Office Witness: _____ Date: _____ _____ Patient initials to indicate copy received