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IT IS IMPORTANT THAT YOU READ AND ACKNOWLEDGE OUR POLICIES AND PROCEDURES IN FULL.

Policies and Procedures:

Payment in full for services and products are due at the time services are performed. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services or products you receive from our office. This includes any medical service or visit, custom or pre-fabricated orthotics, cosmetic treatments such as Keryflex nail restoration or chemical peels etc.

Co-payments will be collected at the time of service. Professional fees, services fees, co-payments, deductibles, custom or pre-fabricated orthotics, Keryflex nail restoration, chemical peels or any products purchased in the office are NOT refundable. There will be a $20 fee for returned checks.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

We bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient.

Patient Responsibility:

I understand and agree I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination,and cosmetic procedures such as keryflex nail restoration or chemical peels.

I understand that while my insurance may confirm benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co –insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that is up to me to obtain a referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. Hillary Brenner DPM PC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Hillary Brenner DPM PC has a summary notice of Privacy Practices and that patient has the opportunity to review this notice. The patient has the right to be informed when their Private Healthcare Information is believed to have been breached. The patient is allowed to restrict PHI disclosure to their health plan if the patient is agreeing to pay out of pocket and in full for services rendered.

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Printed Patient Name (and Guardian Name if applicable)

____ ___________
Patient or Guardian signature Date

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Hillary B Brenner DPM PC Witness

I give permission to communicate my Private Healthcare information to:

_________________ ____________________________
Name Relationship

________________ _______________________________
Name Relationship