

# **Affiliated Foot & Ankle**

## **PAYMENT POLICY**

### **INSURANCE PARTICIPATION**

In an effort to accommodate our patients, Dr. Mistretta and Dr. Filiatrault participate with most insurance plans. Although we are pleased to provide services to our patients, it is impossible for our office staff to be aware of the specific requirements of each and every plan. There may be limitations by your plan on number of visits, laboratories you may use, referrals and authorizations for certain procedures. We ask that you please be familiar with your insurance contract regarding services, exclusions, and expiration dates of referrals. Unfortunately, if you do not inform of us of special guidelines and limitations of your plan, and we subsequently order services or procedures, these will be considered non-covered and will not be paid by the insurance company. *Payment for these services will become your responsibility.* As a courtesy we will file your insurance, but if after 6 weeks your insurance has not responded to the claim filed, you will be notified that the unpaid balance is now your responsibility and payable within 2 weeks of notification.

### **RETURNED CHECK FEE**

There is a \$25.00 fee for all returned checks. If your account is delinquent and is forwarded to collections you will be responsible for all legal and collection fees.

### **LATE FEES**

There is a \$20.00 late fee for all unpaid balances after 45 days past the date of service.

### **CANCELLATION OF APPOINTMENT**

Our office requires 24-hours notice if you are unable to make your appointment. Please notify us as soon as you are aware of any schedule changes. There will be a \$35.00 fee for not complying with this policy. Your courtesy is deeply appreciated so that we may serve you and other patients more efficiently.

I hereby acknowledge that the above information set forth is true and correct, that I have read the above payment policy, understand the contents thereof, and agree by the terms set forth.

\_\_\_\_\_  
**Initials of Patient or Guardian**

\_\_\_\_\_  
**Date**

Please continue on next page.

## **SUMMARY OF NOTICE OF PRIVACY PRACTICES**

### **HEALTH INFORMATION USE AND DISCLOSURE**

The offices of Dr. Mistretta and Dr. Filiatrault understand that medical information about you and your health is personal and we are committed to protecting that information. With that understanding, we will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. We will not use or disclose your health information without your written authorization, except as stated in more detail in the Notice of Privacy Practices. We reserve the right to change this notice and will post a copy of the current notices in effect in our facility.

### **ADDITIONAL DISCLOSURE AUTHORITY**

In addition to the allowable disclosures described in the Notice of Privacy Practices, if you would like to authorize the disclosure of your protected health information to another person(s) please specify by answering the questions below.

In regards to your protected health information, are we allowed to speak with (please circle):

|                                       |            |           |
|---------------------------------------|------------|-----------|
| ~Any member of your immediate family? | <b>YES</b> | <b>NO</b> |
| ~ Your spouse? Name_____              | <b>YES</b> | <b>NO</b> |
| ~Other? Name_____                     | <b>YES</b> | <b>NO</b> |

|   |            |           |
|---|------------|-----------|
| <b>Can we leave messages regarding your health information on your answering machine?</b> | <b>YES</b> | <b>NO</b> |
|---|------------|-----------|

### **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

\_\_\_\_\_  
**Patient Name (please print)**

\_\_\_\_\_  
**Name of Guardian / Authorized Representative (if applicable)**

\_\_\_\_\_  
**Signature of Patient or Guardian**

\_\_\_\_\_  
**Date**