Patient Name: _____ Date of Birth: ____/____/____

PATIENT CONTRACT

1) Payment is expected at time of service. **EXCEPTIONS** to include: Medicare patients, PPO and HMO members.
2) As a courtesy, we will be happy to bill your primary and secondary insurance company on your behalf. It is up to each patient to know the rules and limitations of your policies.
3) You are responsible for any portion not covered by your insurance, such as deductible and/or copay. This amount is due at the time of service.
4) If your insurance company does not make the payment you expect, it is up to the policyholder to contact the insurance company. Our office will supply any documentation necessary to expedite the handling of the claim. Please read you explanation of benefits to determine amounts owed.
5) Any balance past 60 days is considered delinquent, and will be put to patient responsibility.
6) Most insurance companies **do not cover supplies** given from an office setting; payment will be due at the time of service for such supplies **(ABN SIGNATURE WILL BE REQUIRED).** We will attempt to bill these supplies to your insurance company and refund any money received to you.
   If you need to cancel an appointment, please notify us at least 24 hours in advance. We will gladly reschedule your appointment.

FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

COPAYMENTS: by law we must collect your carrier designated copay at the time of service.

REFERRALS: if plan requires a referral from your PCP it is your responsibility to obtain it prior to your appointment.

NON PLAN PATIENTS: Payment is expected at time of service.

MEDICARE: we will submit to Medicare for the entire Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed directly to secondary insurance if you have one.

We accept CASH, CHECK, MASTERCARD, DISCOVER AND VISA.

I have read and understand the above Patient Contract and Financial Policy for Suburban Foot & Ankle Associates.

Signature of Patient, Parent or Legal Guardian _____ Date: ____/____/____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all confidential communication to me from Dr. Basile and staff at Suburban Foot & Ankle Associates be handled in the following manner: **Check all that apply**

Written communication:

❒ to my home address ❒ to a different address _____

❒ to my email address _____

Telephone communication: May leave message on;

❒home number ❒cell phone ❒different number _____

❒with family member ❒answering machine ❒ voice mail

Test Results:

❒May only release test results to myself

❒May leave with results with spouse

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Suburban Foot & Ankle Associates and that I have read (or had the opportunity if I so choose) and understand the Notice

Patient / Responsible Party Signature: _____ Date: ____/____/____