PATIENT FINANCIAL POLICY & HIPAA ACKNOWLEDGMENT

Keystone Podiatry Clinic
2714 Mercer Road
New Castle, PA 16105
Phone: (724) 654-6660

Julie Mrozek, D.P.M.
Adam Thompson, D.P.M.
Ahmad Al-Turk, D.P.M.

Patient Name: _____

Date of Birth: _____

Financial Policy

Thank you for choosing Keystone Podiatry Clinic for your foot and ankle healthcare needs. We are committed to providing quality medical care while helping you understand your financial responsibilities. Please read this policy carefully.

Insurance Authorization

I authorize Keystone Podiatry Clinic to bill my insurance company for services rendered. I authorize the release of any medical or other information necessary to process claims and obtain payment for services provided. I request that payment of authorized insurance benefits be made directly to Keystone Podiatry Clinic.

Insurance Coverage

Although we participate with many insurance plans, participation may vary by plan. It is the patient's responsibility to verify that Keystone Podiatry Clinic and the treating provider are participating with their specific insurance plan prior to receiving services.

Verification of insurance benefits is not a guarantee of payment. Final determination of coverage is made by your insurance carrier.

Patient Responsibility

Patients are responsible for:

- Copayments at the time of service.
- Deductibles, coinsurance, and non-covered services as determined by their insurance company.
- Services denied because of benefit limitations, lack of authorization, or lack of medical necessity as determined by the insurance carrier.
- Charges are incurred when insurance information is not provided at the time of your visit.

Any outstanding patient balance is due upon receipt of the billing statement unless prior payment arrangements have been approved.

Non-Participating Insurance Plans

If Keystone Podiatry Clinic does not participate with your insurance plan, payment in full may be required at the time of service. As a courtesy, we may submit claims to your insurance carrier when appropriate, but reimbursement will be sent according to your plan's policies.

Referrals and Prior Authorizations

If your insurance requires a referral or prior authorization, obtaining it is your responsibility unless otherwise agreed. Failure to obtain required referrals or authorizations may result in denial of payment by your insurance company, and you will be financially responsible for those charges.

Returned Checks

A fee of **$20.00** will be charged for all returned checks or declined electronic payments.

Collection of Outstanding Balances

Accounts with unpaid balances may be referred to a collection agency after reasonable attempts have been made to collect payment. The patient remains responsible for all outstanding balances and any allowable collection costs.

Assignment of Benefits

I assign all medical and surgical benefits, including major medical benefits, to Keystone Podiatry Clinic. This assignment remains in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether they are paid by my insurance.

HIPAA Acknowledgment

I acknowledge that I have received or been offered a copy of Keystone Podiatry Clinic's Notice of Privacy Practices. I understand that this notice describes how my protected health information (PHI) may be used and disclosed and explains my rights regarding my health information.

A copy of the Notice of Privacy Practices is available upon request and may also be posted in the office.

Authorization to Discuss Protected Health Information (Optional)

I authorize Keystone Podiatry Clinic to discuss my protected health information with the following individuals:

Name: _____ Relationship: _____

☐ I do not authorize disclosure of my protected health information to anyone other than myself except as permitted by law.

Communication Preferences

I authorize Keystone Podiatry Clinic to contact me regarding appointments, test results, billing, and other healthcare information by:

☐ Phone

☐ Voicemail

☐ Email

I understand that my email may not always be fully secure.

Preferred Phone Number: _____ Email: _____

Patient Acknowledgment

I certify that the information I have provided is accurate and complete.

I have read, understand, and agree to the Financial Policy and acknowledge receipt of the Notice of Privacy Practices.

I understand that a photocopy or electronic copy of this agreement shall be considered as valid as the original.

Patient/Legal Representative Signature: _____

Relationship to Patient (if applicable): _____

Date: _____