MILWAUKEE
FOOT AND ANKLE SPECIALISTS
MILWAUKEEFOOT.COM

FINANCIAL AND CANCELLATION POLICY

We are pleased to offer you the service of billing your insurance company for the care you have received from our doctors. It is your responsibility to notify us of any changes in your insurance coverage.

Our policy is to have a copy of your credit card on file. If you have a balance over 90 days we reserve the right to charge your card for this balance. We will notify you before we do so. If you choose not to provide a copy of your credit card, we will run a payment today of $100 to use towards any balance.

If you are uninsured, payment is due in full on the date of service, or payment must be made in advance. For insured patients, co-pays and deductibles are due on the date of service provided to you in the office.

The fees we charge for services are usual and customary for this area. Your health insurance policy may base its allowances on a fixed fee schedule that may or may not coincide with our usual fees. You should be aware that different companies may vary greatly in the type of coverage available.

Ultimate responsibility of payment for services rendered is yours.

For our Medicare patients, we agree to accept the charge determination of the Medicare carrier as the full charge. You are responsible only for the deductible, coinsurance, and non-covered services as determined by the Medicare carrier.

I hereby authorize Milwaukee Foot and Ankle Specialists to release to any insurance company, physician, or hospital all medical information which is necessary to afford proper treatment or obtain payment for services. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I have read and fully understand the above, and I realize that I am responsible for any charges not covered by my insurance.

We want to thank you for choosing us as your health care provider. In order to give you and all our patients the best possible care, we request that you review our policy regarding missed and/or cancelled appointments below:

A MISSED APPOINTMENT IS WHEN YOU FAIL TO SHOW UP FOR AN ALLOTTED APPOINTMENT TIME, WITHOUT A PHONE CALL OR CANCELLATION NOTICE OF (AT LEAST) 24 HOURS.

A $50 fee will be assessed for each appointment that fails to comply with the above policy.

I, _____ understand and agree to the terms listed above regarding Milwaukee Foot and Ankle Specialists' financial policy, billing practices, and cancellation policy.

Patient Signature:_____ Date:_____

MILWAUKEE
FOOT AND ANKLE SPECIALISTS
MILWAUKEEFOOT.COM

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Practice's Requirements

This Practice:

A. Is required by law to maintain the privacy of your Private Health Information (hereafter referred to as PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

B. Under the privacy rule, it may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

C. Is required to abide by the terms of this privacy notice.

D. Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for your entire PHI.

E. Will distribute any revised privacy policy to you prior to implementation.

F. Will not retaliate against you for filing a complaint.

Effective Date

This notice is in effect as of April 15, 2003.

Patient Acknowledgement

By signing below, I acknowledge receipt of a copy of this notice.
I have full understanding and am in agreement to its terms.

Patient Printed Name:_____

Patient Signature:_____ Date:_____