

Hettinger Podiatry Center, P.C.
59 Danada Square East * Wheaton, Illinois * 60189-8484

1) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided (or it has been made available to me) a copy of the "Notice of Privacy Practices" and that I have read (or had the opportunity to read if I so choose) and understood the Notice. (Available in office.)

Signature: _____ Date: _____

2) OFFICE PAYMENT POLICY

1. The patient is responsible for payment of services rendered.
2. In an effort to obtain benefits on behalf of the patient, we will file your insurance form for you. In the event that you have multiple insurance coverage, we will file those for you as well.
3. The patient is responsible for those charges approved by the insurance company, but not paid to us. This includes your yearly deductible and co-insurance. Amounts that your particular insurance company considers to be over their specific "usual and customary" benefit will be excluded from your bill.
4. All accounts that are 60 days past due after your insurance company has paid their portion will be considered for turning over to an outside collection agency. Payment plans can be arranged for larger balances, or placed on your VISA or MasterCard upon request.

I UNDERSTAND THE ABOVE OFFICE PAYMENT POLICY AND AGREE TO THE AFOREMENTIONED CONDITIONS OF THIS POLICY. I MAY REQUEST A COPY OF THIS POLICY, AND ANY POLICY PROCEDURES THAT I DID NOT UNDERSTAND HAVE BEEN EXPLAINED TO ME BEFORE I SIGNED.

SIGNED: _____ DATE: _____

3) AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above named physician to release information acquired in the course of my examination or treatment necessary to process medical insurance claims or to discuss your conditions with your listed family physician.

Signed (Patient, or parent, if minor) _____ DATE: _____

4) AUTHORIZATION TO PAY

I hereby authorize payment to the above named physician of surgical and/or medical benefits, if any, otherwise payable to me for this service. I understand that I am financially responsible for those charges not paid by my insurance.

Signed (Insured Person) _____ DATE: _____