FINANCIAL POLICY

Thank you for choosing our practice for your healthcare needs. The following is our Financial Policy, which we ask that you read and become familiar with. In order to control costs and provide our patients with quality care, your cooperation is necessary.

- We are committed to providing the best treatment for our patients, and our charges are within the ranges of what is usual and customary for this area. **Any amount owed the day of services are rendered is an estimation based on what your insurance will allow.**

- **CO-PAYS, ANY UNMET DEDUCTIBLES, AND CO-INSURANCE** MUST be paid at the time services are rendered, as required by your insurance company.

- **REFERRALS:** If your insurance company requires you to have a referral from your primary care physician in order to be treated by Dr. Nelson, we must have it in order for you to be seen. You will need to contact your family doctor to request one and reschedule your appointment once we obtained it. Example: any Soonercare (Medicaid primary) patients.

- **INSURANCE CLAIMS:** Insurance Claims for services rendered will be completed and filed by our office. Please be sure to supply our staff with the accurate insurance information and a copy of your insurance card. If we are unable to verify your insurance then your entire bill will be your responsibility.

- **BILLING STATEMENTS:** You will only receive a statement from this office when the owed amount it your responsibility. Please pay your bill promptly. If you feel that your insurance carrier has not paid correctly, contact them instead of us or our billing office. We will not be able to provide you with any specific information regarding your particular insurance policy.

- **SELF-PAY:** If you do not have insurance, **PAYMENT IN FULL IS EXPECTED** at the time of service unless you have made prior arrangements with us.

- **MINORS: Unaccompanied minors will not be treated.**

A $25 fee will be charged for missed appointments. Cancelations must be made at least 24 hours in advance.

- **MEDICARE PATIENTS:** As a participating provider, we must accept Medicare's allowed charges for the services rendered. Medicare will send a check directly to our office for 80% of the approved amount. The patient is responsible for the 20% of the approved charge plus **YEARLY deductible of $147.00** if it has not been met. Although we accept assignment for the Medicare patients, *the beneficiary, as required by federal law, is responsible for 20% of the approved amount and also for any routine services not covered by Medicare*. If you have a secondary insurance, we will submit a claim for any remaining balance after Medicare has paid.

- **WORKER'S COMPENSATION:** We are happy to provide treatment for work related injuries. However, all charges incurred are ultimately the responsibility of the patient. You must supply us with your date of injury, allowed diagnoses and your claim number. Payment from the patient is expected, unless we receive the necessary information to submit a claim for services rendered. WE WILL NOT BILL YOUR PRIVATE INSURANCE CARRIER WITH WORK RELATED INJURIES.

- **PAST DUE ACCOUNTS:** Accounts that are 90 days past due will be sent to an outside collection agency.

- **MEDICAL POWER OF ATTORNEY:** The patient will need to sign all paperwork unless a medical power of attorney is documented.

- **DURABLE MEDICAL EQUIPMENT:** Most insurance companies, including Medicare do not cover durable medical equipment. We often use those items for your appropriate care. You will be responsible for these purchases and will be expected to pay in full the day of service. Items commonly used include but are not limited to: custom & pre-made orthotics, surgical shoes, foot and toe pads, walking boots, braces and heel lifts.

- **NON- REFUNDABLE:** All medical supplies and custom orthotics and inserts are non-refundable. Payment it dues the day they are dispensed.

- **PAPERWORK FEES:** We have the right to charge for any records or copies of paperwork requested. There will also be a charge for any forms that need to be completed by the doctor or staff. Also, to be able to receive your records you will need to fill out a records release form and give us at minimum a week to get your documents together.

I authorize Dr. Nelson to:

Provide diagnostic and treatment services

Furnishing my insurance company or Medicare with all the necessary information regarding my present illness or injury.

Accept payment of medical benefits for medical supplies or services provided, with understanding that any overpayment will be reimbursed to me promptly

By signing below you have read and agree to our Financial Policy

Payment is REQUIRED at the time services are rendered. If you are unable to pay our bill, we will need to reschedule your appointment. Also any missed appointments without letting us know 24 hours in advance will have a $25 charge.

_____ _____

Patient Date

_____ _____

Patient/Guardian Date

ALL PAPERWORK MUST BE FILLED OUT!

Is this workers comp?
Yes or No

Patient Name_____
Last First Middle

Mailing Address_____ City_____ Zip_____

Patient SS# _____ Birthday_____
Martial Status (S)__ (M)__ (D)__ (W)__ (Other)__

Best number to reach you _____Cell_____

Home Phone_____ Other_____
How would you like to be contacted for your reminder call? Home phone___ Cell phone___ Text___ or Email____. Email address_____

Name of Primary Insurance_____

Policy Holder Name_____ Relationship_____

Birthdate_____ Policy Holder SS# _____

Name of Secondary Insurance_____

Policy Holder Name_____ Relationship_____

Birthdate_____ Policy Holder SS# _____

Have you been to a Podiatrist before? Yes____ No_____

If yes who? Name_____ Last Visit_____

If a patient is a minor or has a guardian please fill in the responsible party

Responsible party_____ Relationship_____

Address_____ City_____ Zip_____

Phone Number(s) _____

Chief Complaint for which you came to be treated for? _____

_____

Please indicate which foot problems you are now having or have had in the past.

Ankle pain____ Athlete's Foot___ Bunions___ Corns and Calluses___ Flat Feet___ Heel Pain___

Cramps or Numbness in feet or legs___Ingrown toenails___ Plantar Warts___ Swelling in Ankles/feet___

Medical History

Is there any personal or family history of Diabetes? Yes___ No___ If yes what type_____

Parents deceased? Yes or No, Mother_____ Father_____

Surgeries you have had _____

_____

_____

Medications including prescriptions, over-the-counter medications and vitamins_____

_____

_____

_____

Allergies_____

_____

Are you allergic to: Adhesive tape___ Local Anesthetics___ Anticoagulant Therapy___ Novocain___

Aspirin___ Penicillin___ Codeine___ Seafood___ Demerol___ Sulfa___ Iodine___

Family Doctor _____ Phone _____

Pharmacy _____Phone_____

Home Health Agency _____ Phone_____

Medical History

Circle all that apply: Past or Present

Acid Reflux	YES	NO	Gout	YES	NO
Aids/HIV	YES	NO	Heart Disease	YES	NO
Alzheimer	YES	NO	Hepatitis A,B,C	YES	NO
Anemia	YES	NO	Hyper Cholesterol	YES	NO
Anxiety	YES	NO	Hypo Cholesterol	YES	NO
Arthritis	YES	NO	Hypertension	YES	NO
Asthma	YES	NO	Hyperthyroidism	YES	NO
Atrial Fibrillation	YES	NO	Hypothyroidism	YES	NO
Bipolar Disorder	YES	NO	Insomnia	YES	NO
Blood Clots	YES	NO	Kidney trouble	YES	NO
Cancer	YES	NO	Liver trouble	YES	NO
Cardiac	YES	NO	Lung trouble	YES	NO
Cellulitis	YES	NO	Lupus	YES	NO
CHF	YES	NO	Migraines	YES	NO
COPD	YES	NO	Neuropathy	YES	NO
Dementia	YES	NO	Osteoporosis	YES	NO
Depression	YES	NO	Parkinson's Disease	YES	NO
Diabetes	YES	NO	Schizophrenia	YES	NO
Epilepsy	YES	NO	Sleep Apnea	YES	NO
Fibro Myalgia	YES	NO	Stroke	YES	NO
Glaucoma	YES	NO	Tuberculosis	YES	NO

Do you smoke? _____ How often? _____

Do you drink alcohol? _____ How often? _____

Illicit drug use? _____

Do you exercise? If yes what type of exercise do you do? _____

_____

Signature of patient _____ Date _____

Signature of parent/Guardian _____ Date_____

Emergency Contact & Release to Discuss Medical Information

I, _____ give Dr. Bradley Nelson D.P.M. or any person representing him permission to give medical information regarding my hospital or medical office records, lab results, x-ray results, etc. to the following person:

Name _____

Relationship_____ Phone_____

Name _____

Relationship_____ Phone_____

Name _____

Relationship_____ Phone_____

Name _____

Relationship_____ Phone_____

Please Note:

Any person not listed above on this contact form signed by you WILL NOT be able to obtain any information from Dr. Nelson or any persons representing him. If you are 18 years of age or older and living at home, we must have a signed consent form from you before Dr. Nelson can discuss any medical information about you with your parents.

_____ _____

Patient or Parent (Guardian) Signature Date

Acknowledgement of receipt of notice of Privacy Practice

The notice of Privacy Practices described how the Foot & Ankle Clinic of Western Oklahoma
And the individual members of its professional staff may use and disclose our medical information and how you can get access to this information. Please review it carefully. If you have any questions about the notice, please contact DHHS at 200 Independence Ave, S.W. Washington, D.C: 20201, HHS.MAIL.GOV

Acknowledgement of notice of privacy practices:
A complete copy of the facility's notice of privacy practices is posted in the facility. By signing below you acknowledge that you have viewed a copy of the facility's notice of privacy practices.

_____ _____

Signature of Patient Date

If the patient is a minor or is incompetent: I hereby acknowledge that I have viewed a copy of the facility's notice of privacy practices on the behalf of the patient.

_____ _____

Signature of person authorized to consent for patient Date

_____

Relationship to Patient