THUNDERBIRD
FOOTCARE
Podiatric Medicine & Surger

HIPAA PERMISSION AND FINANCIAL POLICY

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Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. By signing this form, you acknowledge that you had the opportunity to review the Thunderbird Footcare, Notice of Privacy Practices, describing the use and disclosure of protected health information about you regarding treatment, payment, health care operations and other uses and disclosures as stated in our Notice.

I GIVE MY PERMISSION TO DISCLOSE MEDICAL INFORMATION, INCLUDINGING FINANCIAL INFORMATION TO THE FOLLOWING PEOPLE.

FAMILY OR FRIEND NAME:_____

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- I authorize and request that the payment of Medicare and/or insurance benefits be made directly to Thunderbird Footcare.
- Patients are responsible for all authorizations/referrals needed to seek treatment in this office.
- Copay, deductibles and coinsurance are due at the time of service.
- Filing insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date services are rendered.
- We have made prior arrangements with insurers and other health plans to accept assignment of benefits.
- We will bill plans with agreements and will require you to pay the copay, coinsurance or deductible.
- If your health care plan determines a service is "not covered" you will be responsible for the complete charge.
- You must inform our office of any insurance changes and authorization referral requirement.
- There are certain elective surgical procedures that we require pre-payment. Our office will notify you of any out of pocket patient costs that are due prior to your surgery.
- Past due accounts are subject to collection proceedings. An additional 50% of your balance will be added to your collection amount as well as any collection costs incurred by our agency or attorney.
- **A No Show fee of $50.00 will apply to any appointments missed or not cancelled within 24 hours notice.**
- **A finance charge of 8% will begin to accrue after 30 days for any unpaid or outstanding balances.**
- **All returned checks for insufficient funds will be charged a $25.00 service fee.**

PATIENT SIGNATURE:_____ **Date:**_____

Email Address: _____