Kansas City Institute of Podiatry

JEFFREY T. ROITH, DPM
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OFFICE FINANCIAL POLICY

This sheet has been prepared for your benefit. It contains information regarding our billing and insurance procedures. If you have any questions regarding the following policies, please feel free to talk to us about them.

Our office operates on a fee for services basis. All co-pays are due at the time of service. We will file all insurance claims. If we are not contracted with your insurance company, all charges including examination, consultation, x-rays and special tests performed in the office are due and payable in full at the time of service. We will accept cash, personal checks, money orders, MasterCard, Visa, and Discover. If other arrangements are necessary please discuss them with our office manager **BEFORE** you see the doctor.

Payment of the doctor's fee is the personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patient's charge is covered, in whole or in part, by insurance. **It is your responsibility to know what is and is not covered by your insurance company. It is your responsibility to know whether or not the doctor you are seeing is contracted under your plan.** Full payment is expected within 30 days. Any statement not receiving a payment after 30 days is past due. There will be a $10 monthly late fee and all balances will be assessed a 1% monthly late charge each month on all balances that are not paid within 30 days. There is a $30 fee for any check that is returned for insufficient funds. For those patients requiring a referral from their primary physician, as requested by your insurance company…**please note**…it is **YOUR** responsibility to obtain these before coming in for an office visit and/or surgery. Thank you for your cooperation.

I authorize the release of any medical or other information to my insurance company as they request. I agree that a photographic copy of the authorization is a valid as the original.

I hereby authorize payment of medical benefits directly to **Kansas City Institute of Podiatry, Jeffrey T. Roith, DPM** and/or **Sarah E. Russell, DPM** and/or **Jason W. Burkle DPM** for the services described on the attached claim form.

I understand that regardless of performance by my insurance company I am responsible for payment of my account. In the event that I should default or my account should become seriously delinquent, I agree to pay all reasonable collection costs including but not limited to attorney fees, agency fees, court costs, and the like.

I, ______________________________, have read the above financial policy and understand my obligation.
Patient's Name (Printed)
Signature:_____________________________________ Date __________________________

OUR POLICY REGARDING RELEASE OF PROTECTED HEALTH INFORMATION

We are more than happy to forward a copy of your medical records to another physician per your request. You must complete an Authorization For Disclosure of Protected Health Information form (available in our office), and a fee may be charged for handling and reproduction. No original X-rays will be released per HIPAA guidelines. However, a quality digital reproduction will be made available upon request. Please provide a reasonable amount of time for copying.

I have read the above release of information policy and understand its content.

Signature: ___________________________________ Date __________________________

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