Please thoroughly read each Hoosier Foot and Ankle, LLC Policy, initial next to each policy and sign below:

Treatment Agreement

____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

____ For the purpose of payment, I allow ***Hoosier Foot and Ankle, LLC*** to release my Private Health Information to any and all of my insurance carriers, their third party payers and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The Hoosier Foot and Ankle, LLC HIPAA rights are also posted in lobby and at www.hoosierfootandankle.com.

Patient Financial Policy

____ You must provide personal (address, phone numbers, email address, etc) and/or insurance changes (carriers, networks, id numbers, etc) to the office at least 2 days prior to your appointment. In the event the office is not informed, you will be responsible for any charges denied.

____ You are responsible for all authorizations/referrals/pre-certifications needed to seek treatment with Hoosier Foot and Ankle, LLC physicians.

____ Your portion of payment for ALL office services is due **at the time of service**. We will accept VISA, MasterCard, Discover, cash or personal check.

____ Your insurance policy is a contract between you and your insurance company. **As a courtesy**, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.

____ Please honor our 24 reschedule/cancellation notice. Repetitive broken or cancelled appoints and/or non-compliance may result in a discharge from Hoosier Foot and Ankle, LLC offices. Any appointment where a language or hearing interpreter is requested a 48 hour notice of reschedule or cancellation will be required. If proper notice is not provided the patient will be billed any fees incurred for this service that is not utilized by that patient.

____ We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and **will require you to pay the copay/coinsurance/deductible at the time of service.** Your upfront portion will be calculated based on your insurance benefit/limits and our negotiated fee agreement with your carrier. If you are seeing our doctors on an 'Out of Network" basis, you will be subject to out of network rates.

____ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, **you** will be responsible for all charges. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

____ Our office will file with secondary and tertiary insurances. For all other insurances, we will provide an itemized statement upon your request. If you possess two or three insurance plans, you MUST notify us of your designated PRIMARY and SECONDARY policy holder.

____ Pre-scheduled Surgical procedures require prepayment/estimated deposit. Your deductible/co-insurance/co-pay for this procedure is due at the pre-operative appointment. For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

____ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment

bill your health plan. Any balance due is your responsibility.

____ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions must be agreed upon in writing.

____ I understand that I am responsible for any outstanding balance remaining after insurance remittance has been received. A collection fee of 20% will be applied to outstanding balances past 60 days. Any balance not paid after 150 days may be referred to an attorney or collection agency. You agree to be responsible for all charges incurred including but not limited to interest allowed at the current legal rate, collection agency fees, reasonable attorney fees and court costs.

____ Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the Hoosier Foot and Ankle, LLC and patient relationship.

____ There is a service fee of $25.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of NSF or any other reason will be filed with the local authority for collection and fines.

____ **Hoosier Foot and Ankle, LLC** will attempt to issue patient refund checks, if applicable, within 90 days of a completed investigation of the potential overpayment.

____ ONLY UNWORN and NON-custom items are returnable within 3 days of receipt. Custom items are NON-RETURNABLE.

____ In the case of divorced parents, payment is expected from the person signing this document and will be considered the guarantor for all payments for any services provided. Hoosier Foot & Ankle will not recognize any divorce decrees regarding reimbursement for medical services for any minor child of divorced parents.

____ College students with health insurance under their parent's name will not be treated by any physician from Hoosier Foot & Ankle without written permission from parent or guardian. Original signature or fax is allowable.

Authorization of Payment

____ I hereby assign all Medical benefits directly to ***Hoosier Foot and Ankle, LLC*** for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and require your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

Patient's Name: _____ Signature of Patient/Guardian: _____ Date: _____

Office Witness: _____ Date: _____ _____ Patient initials to indicate copy received