

OUR POLICY REGARDING YOUR HEALTH INSURANCE

So that we may preserve the best possible relationship with our patients, we hope that the following explanation of our position on Health Insurance carriers will be helpful:

1. The proper relationship between patients, doctor, and insurance carrier is often misunderstood. We render to you our very best care, and charge you a fee for that service. Just as the insurance companies do not allow us to set their premium rates, we cannot allow them to set our fees or determine which procedures are best for you. These fees are mutually agreed upon between you and us, and the insurance carrier does not enter into this relationship.
2. Insurance policies vary in the amount that will be paid towards any charges. *Please be aware of your copayment responsibilities*, and that there *may* be balances due after your insurance has made its payment, *which will be your responsibility*. We will bill you for these balances, and expect prompt payment.
3. Our services are rendered to you, not the insurance company. *You have final responsibility to see that all services are paid.*
4. Our office will be happy to file your primary insurance claims for you. Please make sure that we have all of the proper information to do so. If a special form is required, please complete and sign it before providing it to us.
5. If you have more than one insurance, please be aware that we do not file to most secondary carriers. *We will file to your secondary insurance if we are in their network*. If you receive a bill from us for any balance, and you have a secondary carrier, this means that we do not file to that insurance company as a secondary payer, and *it is your responsibility to do so.*
6. It is your responsibility to call your insurance company with any questions you have regarding your coverage. If your plan requires you to obtain *referrals to specialists*, please comply with this requirement and *see that we have all of the necessary documentation prior to your visit.*

I understand and agree to the above statements. I also authorize payment of medical benefits to the above named physicians for services provided to me, or any member of my family, covered under my insurance plan.

I authorize the release of any medical or other information necessary to process my medical claims.

Signature _____

Date _____

**FOOT & ANKLE INSTITUTE OF NEW ENGLAND
KENT COUNTY SURGICAL CENTER
MEDICAL PRIVACY POLICY**

1. All patient information is confidential.
2. Every attempt will be made to respect confidentiality when communicating with patients.
3. Patients will be informed of this policy upon entering the practice yearly thereafter.
4. It is our policy to release patient information to other providers only with written patient consent.
5. Only patients themselves may call for test results unless they have authorized us to give information to family members.
6. Employees will review this policy initially and yearly thereafter.

TO PATIENTS:

At times the office may need to contact you regarding:

Test Results
Insurance Claims
To Confirm an Appointment

If we call and you are not available:

May we leave a message on an answering machine at home? Yes No

May we leave a message on an answering machine at work? Yes No

May we leave a message with a family member: Yes No

May we leave a message with a co-worker? Yes No

If yes, name of person _____

Please indicate the best telephone number for us to reach you _____

Patient Signature _____ Date _____

Please Print Name _____