New Tampa Foot & Ankle

Dr. Stephen F. Levin
Board Certified in Foot Surgery

FINANCIAL AGREEMENT, *page 1 of 2 (signature on page 2)*

Dr. Stephen F. Levin, D.P.M., P.A., d/b/a New Tampa Foot & Ankle, has outlined the following:

Co-Pays
- It is our policy to collect your insurance copay at the time of service.

Co-Insurance/Deductibles
- Every effort is made to fairly estimate the co-insurance and/or deductible owed based on the nature of the visit, and these are collected at the time of service.

Billing
Filing your benefits is a COURTESY that we provide. We will do everything that we can to help you get your full insurance benefit, but we will not guarantee what your insurance plan will pay.
- **ID and Insurance Card:** It is critical that the most current insurance card(s) and corresponding photo ID are brought to every appointment. We must have the correct information at the time of service. An insurance card is like a credit card; the information must be current and valid for it to be used.
- **Auto Insurance/Workman's Comp:** We do not participate in the treatment or filing of auto insurance or workman's comp claims.
- **Supplemental/Secondary Insurance:** We automatically bill according to Medicare guidelines.

Medicare
- We are a Medicare Provider; therefore, we do accept assignment on Medicare.
- When possible, your claim will be filed to Medicare and any supplemental/secondary insurance.
- For those patients who do NOT have a supplemental/secondary he/she will be required 20% of the total bill to be paid at the time of service
- Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered medically necessary under the Medicare Program. We will discuss these charges with you prior to a service if we know it will not be covered by Medicare.

Durable Medical Equipment (DME) & Retail Policy
Durable Medical Equipment (DME) such as custom total contact orthotics, walker boots, night splints or any type of ankle support devices are **non-refundable**.

- We collect the following **deposits** for these DME items:
  - Custom Orthotics: $450: $225 is due at the time of casting and remaining $225 is due at pick up
  - Walker Boots: $150
  - Equinus Brace: $175
- Please be advised, that even though we bill the item to your insurance, you may still owe a balance as we only collect a deposit.

FINANCIAL AGREEMENT, *page 2 of 2 (signature on page 2)*

New Tampa Foot & Ankle: 26827 Foggy Creek Road, Suite 104, Wesley Chapel, FL 33544
Office: 813-973-3535 **Fax: 813-907-2963**
www.NewTampaFootandAnkle.com

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Durable Medical Equipment (DME) & Retail Policy, *continued*

- All retail items are considered out of pocket and we **cannot** bill them to the insurance company. **All sales are final and non-refundable.**
- All **second pair of orthotics and refurbishment of orthotics** are considered retail products and are not billed to the insurance company. All sales are final and non-refundable.

Administrative Fees & Policies

Dr. Stephen F. Levin, D.P.M., P.A., d/b/a New Tampa Foot & Ankle, charges various fees for the following items, which require personnel and resources to address:

- Copies of medical records
- Completion of forms such as FMLA and short-term disability
- Medication prior authorizations
- Special request physician letters
- Returned checks (for insufficient funds)
- No-Show fee: Assessed if you do not show up for a scheduled appointment.
- Surgery administrative fee
- All accounts must be paid upon receipt of our bill. If after 60 days, the balance is not paid in full; your account will be sent to our collection agency for the balance, plus a fifty percent (50%) collection fee.
- Minors **must** be accompanied by a parent or legal guardian, with the Minor Consent for Medical Treatment form filled out.
- We accept credit/debit card payments at time of service

If you have any questions about the above information, we will be glad to answer your questions. I have read the Financial Agreement. I understand and agree to the Financial Agreement.

I, the undersigned, authorize payment of the medical and surgical benefits directly to Dr. Stephen F. Levin, D.P.M., P.A. and to release information including the diagnosis and the records of any such medical or surgical care. I am also giving Dr. Stephen F. Levin, D.P.M., P.A., d/b/a New Tampa Foot & Ankle, all rights to inquire on my behalf on any medical reviews relating to my medical benefits, either assigned or non-assigned.

Patient/Guardian Signature: _____ **Date:**_____

Printed Name: _____

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:
(Print Patient Name)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read them or declined this opportunity to read them and understand the Notice of Privacy Practices.

The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restriction that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me. I understand that if I do not sign this Consent evidencing my Consent to the uses and disclosures described to me above contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the forgoing notice, and all my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship (Att-In-Fact, Parent of a minor)

Date Signed: ____/____/_____ Witness: _____

Please list any person that you authorize our office to communicate with on your behalf to discuss aspects of your care such as diagnostic and lab results.

Name of Authorized Person	Authorized Person's Date of Birth	Relationship	Authorized Person's Address

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