



Office Policies and Procedures

We would like to take this opportunity to personally thank you for choosing Hays Foot and Ankle Center to treat your podiatric needs and concerns. Below is a list of our office policies. Please take a moment of your time to review our policies and please do not hesitate to ask any questions. **After reviewing the policies below, please initial next to each policy indicating you have read, understand, and will adhere to the written policies. Either typed or hand-written initials will constitute this acknowledgement.**

- _____ **Patient Treatment:** It is our primary goal to restore and maintain the health of your feet. We strive to provide you with the highest quality podiatric care. If you have any questions regarding your treatment, please feel free to consult with your physician who is providing your care. It is our responsibility to deliver the best health care possible. We highly value your confidence in our practice and we will make a sincere effort to satisfy all your podiatric needs.
- _____ **Appointments:** If you are unable to keep your appointment we require that you contact our office. As a courtesy to other patients who are waiting for an appointment, we request that you call to cancel your appointment within 24 hours. Also as a courtesy to the doctor and to other patients, we require that you be on time for your appointment. When you are late, you put the doctor behind schedule with their other patients.
- _____ **Release of Records:** If you want your records released to another physician or facility you must sign a Release of Information form indicating who we are releasing records to, as well as, which relevant information you would like us to release. If you wish to receive a copy of your records for your personal files, you must send us a written request. Please allow 7-10 business days to have your records available. I hereby authorize Dr. Hays to furnish information to insurance carriers concerning this illness/accident. I realize my records may be electronically transmitted and through some default may not be received by the intended recipient. Should this occur, I release Dr. Hays from all liability.
- _____ **Referrals:** If your insurance company requires a referral, it is your responsibility for obtaining it. The contract is between you and your insurance carrier. Therefore, we are not responsible to obtain you referral. If you present to the office without your referral you will be required to reschedule your appointment or you may opt to payout of pocket for services rendered. Referrals must be generated from your primary care physician or referring doctor.

_____ **Insurance:** Your insurance coverage is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company (primary and secondary, if applicable) as a courtesy. Your insurance company does not guarantee payment for services rendered. Your insurance company makes the final determination of benefits and eligibility at the time the claim is reviewed. By signing the line below you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance carrier.

_____ **Verification of Benefits:** You as the policyholder are primarily responsible to know your insurance benefits. We may assist you, if time permits to verify your podiatric coverage available under your policy. The insurance DOES NOT guarantee payment of the benefits quoted and subsequently you will be responsible for any coinsurance or deductibles for services not covered by your insurance carrier. We must have a copy of your insurance card and photo ID in order to process your claim. Therefore, please give your cards to the receptionist. If you are a first-time patient, or if your insurance information has changed, we must be notified. Failure to cooperate will mean that you will be responsible for the charges incurred.

_____ **Required Payments:** You be will be responsible to pay any co-payment, deductible, coinsurance, or fees not covered by your insurance carrier at the time services are rendered. Any outstanding balances greater than 60 days must be paid prior to being seen by the physician or you will be required to reschedule your appointment. You may choose to pay by cash, check, or Credit Card.

_____ **Monthly Statements:** You will receive a statement only if you have an outstanding balance on your account. The statement will reflect any balance pending with your insurance carrier as well as any outstanding balance for services not covered by your insurance company. We request that if you receive a statement, that you make payment within 30 days of receipt. If your balance becomes delinquent past 90 days, your account will be referred to a collection agency.

Signature: _____ Date: _____