Kent Foot & Ankle Center

Patient Policies

Appointments:

1. Patients who wish to cancel or reschedule an appointment must give 24 hour's notice. Patients who fail to keep appointments, or who cancel with less than 24 hour's notice, will be charged a non-refundable reschedule/ no-show fee of $25.00. If this occurs more than once, the patient may be discharged from the practice. This fee must be paid prior to scheduling a new appointment.
2. If you are enrolled in a managed care plan, your insurance carrier will be notified of your no-show/missed appointment record with our office.

Health Insurance Portability and Accountability Act (HIPPA) Privacy Options. Please Circle one

1. May we call and leave a message on your answering machine? Yes No
2. May we leave a message with anyone who answers the phone regarding your appointment, condition, or medical information? Yes No
3. May we discuss your medical condition, insurance issues, and/or billing questions with anyone other than yourself? Yes No
   If yes, to whom may we speak with? _____ Relationship: _____

Appointment Hours

Dover Office:	Monday, Tuesday, Thursday	8:00am to 5:00m
	Wednesday	8:00am to 6:30pm
	Friday	8:00am to 4:00pm

Filing to your Insurance:

We will be glad to bill your primary and secondary insurance carries provided we have all of the information at the time of your visit. Once your visit has been filed to the insurance carrier(s), we will not re-bill based on bad information you provided at the time of your visit. You will be responsible for payment in full and following up with your insurance carrier. If payment is received from your insurance carried, we will gladly refund any overpayment made.

Patient Balances:

Patient statements will be sent our regarding balances due. If your account is 3 months overdue, your account will be referred to a Collection Agency for payment. If your account is sent to a Collections Agency, a collections fee of 40% of your balance due will be added to your account and NO appointments will be made until the balance is paid in full. We will gladly make a payment plan with you as long as you have made arrangements with our billing department.

By signing this document, you agree to all of the above.

_____ Date_____

Patient or Legal Guardian (If a minor)

_____ Date_____

Print Name of Patient