SunsheinPodiatry
SM

Kevin F. Sunshein, D.P.M.
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons

Rodney L. Carlson, D.P.M.
Podiatric Physician and Surgeon

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

This notice is available in both Hard Copy form and PDF format on the web site www.sunsheinpodiatry.com.

_____ _____

PATIENT NAME (Please Print) DATE:

_____

PARENT OR AUTHORIZED REPRESENTATIVE (If Applicable)

_____

SIGNATURE

Centerville Office
6474 Centerville Business Parkway
Centerville, Ohio 45459

937/435-7477
Fax 937/435-6644

www.sunsheinpodiatry.com

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24 HOUR CANCELLATION & "NO SHOW" FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Sunshein Podiatry Associates will charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled within a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Two "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Printed Name _____ Date _____

Signature _____

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FINANCIAL POLICY

Dr. Sunshein and Associates wishes to welcome you to our practice. This information sheet will describe our standard office policies and procedures.

As a courtesy to our patients, we will bill your primary insurance carrier for all covered services. Payment of all applicable copay's, deductibles and non-covered services is expected at time of service. Your insurance company requires copays at time of service. A $10.00 surcharge is made in addition to all copays not paid at time of service. For your convenience, we accept MasterCard and Visa. You will be informed of all non covered services prior to them being rendered. Miscellaneous supplies and foot comfort items are not billed to any insurance companies. Most insurance companies including Medicare do not pay for routine foot care such as trimming or debridement of toenails, corns and calluses. Payment for these services is expected at time of service and timely payment of these services does help keep our costs down. Our fees are very competitive but represent the professional care given to all of our patients.

We participate with many insurance companies. While we are very knowledgeable concerning insurance matters, recent changes in health care require patients be pro active in their medical care. A common question that patients ask the doctors is why their insurance company does not pay for certain services. Although we are sensitive to all of our patients needs we can not answer those particular questions and it is recommended that you contact your insurance company concerning those issues.

Since we provide both primary and specialty foot/ankle care, referrals are often required by your insurance coverage. **IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN A REFERRAL FOR OUR SERVICES.** If a referral is required and one is not available at time of service, then full payment is expected when services are rendered.

We bill all insurance companies as a courtesy to our patients but we remind you that our relationship is with you and not your insurance company. You are responsible for payment for all services rendered. **While we do participate with several hundred insurance plans, not all of our doctors are on the same plans. PLEASE CONTACT YOUR INSURANCE CARRIER TO SEE IF OUR DOCTORS ARE ON YOUR PLAN.** If your secondary insurance company does not pay us within 30 days of being billed then the balance will be turned over to you and payment is expected at that time. Unpaid patient balances are subject to a monthly service fee of $5.00. Returned check fees are $15.00.

I understand and agree to comply with the office policy concerning payment for services.

PATIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE: _____

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