

BRIELOFF FOOT CENTERS

PETER N. BRIELOFF, DPM, PA.
805 E OLDTOWN ROAD, SUITE B
CUMBERLAND, MD 21502

BLACKBURN SQUARE
RTE 3 BOX 6
KEYSER, WV 26726

WELCOME TO OUR OFFICE

PATIENT INFORMATION

NAME _____ DATE _____
FIRST INITIAL LAST

BIRTHDATE ___/___/___ AGE ___ SOCIAL SECURITY# ___-___-___ SEX ___M ___F

MARITAL STATUS ___M ___S ___D ___W STUDENT ___Y ___N

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

HOME ADDRESS _____

CITY _____ STATE ___ ZIP CODE ___ HOME PHONE # _____

FAMILY DOCTOR _____ PHARMACY _____

EMPLOYER _____ WORK / CELL PHONE # _____

E-MAIL ADDRESS: _____

HOW DID YOU HEAR OF OUR OFFICE? _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

NAME OF POLICY HOLDER _____ **POLICY HOLDER DATE OF BIRTH** _____

HOW MAY WE CONTACT YOU? (CHECK ALL THAT APPLY) ___PHONE ___MAIL ___E-MAIL

PATIENT AUTHORIZATION

I authorize Peter N. Brieloff, DPM, PA to apply for benefits on my behalf for services rendered by Dr. Peter N. Brieloff. I request payment from my insurance company to be made directly to Peter N. Brieloff, DPM, PA. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I will notify you of any changes to my health status or the above information. I permit a copy of this authorization to be used in place of the original. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I also give permission to the Brieloff Foot Centers to release information regarding my care to any party involved in my healthcare.

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

I have also read the **Patient Financial Policy** and understood the Financial Policy and agree to comply with this policy.

SIGNATURE _____ DATE _____

PARENT OR GUARDIAN (if patient is a minor) _____ DATE _____

Brieffoot Centers

Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or office manager.

- As our patient, **you are responsible for all authorizations/referrals** needed to seek treatment in this office.
- As our patient **you are responsible for all co-pays and deductibles. Co-pays are due at the time of service.**
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- **Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, you will be responsible for payment.**
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- There is a service fee of \$25.00 for all returned checks. There will also be a \$25 service fee for each rebilling of a patient balance if payments have not been made. Your insurance company does not cover these fees.
- The patient or responsible party will be responsible for any additional fees associated with a claim going to a collection agency or attorney.