Jacob B. Goldstein, DPM, LLC • 230 E. Main St • Gardner, KS 66030

Financial Policy

We will process your claim for services rendered by the doctor and we will assist you with any required pre-certification for procedures or devices ordered by our office. It is important for you to be aware of any limitations of your benefits. It is ultimately your responsibility to verify whether any care you receive is covered by your insurance plan. This office is not responsible for the treatment expense which is not paid by your insurance. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid by your insurance. By law, we are obligated to charge for these. Any co-payment is charged at the specialty rate and is required prior to the office visit.

It is your responsibility to have up to date insurance information and co-payment amount and to immediately advise us of any payment received from insurance or any 3rd party for our services.

Unless prior financial arrangements have been made, an account with a balance greater than 90 days past due will be reported to a collection agency and will incur a $15.00 administrative fee. We offer credit card processing and payment plans to assist in meeting your financial obligations to our office. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. Returned checks for insufficient funds will incur a $25.00 charge.

CANCELLATION POLICY: Except as a result of an emergency (immediate threat to life, health, property, or environment) or a family crisis, any patient who fails to show for a scheduled appointment and did not provide at least a 24 hour notice of the need to cancel the appointment, will be considered a “No Show” and may be charged a $40.00 fee. This fee is billed directly to the patient since it is not covered by insurance. A “No Show” for a scheduled surgical procedure will incur a $200.00 charge. These charges will be billed directly to the patient. This fee is not covered by insurance and must be paid prior any future appointment.

**** I understand these policies and accept responsibility for payment of my account.**

Authorization to Release Medical Benefits

I authorize the release of all medical information necessary to process insurance claims and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Jacob B. Goldstein, DPM.

To the extent necessary to determine liability of payment on to obtain reimbursement, I authorize disclosure of portions of for all of my (the patient' s) medical record.

This assignment will remain in effect until revoked by me in writing. A signed photocopy of this assignment will be considered as valid as an original.

Medicare Lifetime Signature on File

If applicable, I request the payment of authorize Medicare benefits be made on my behalf to Jacob B. Goldstein, DPM for any services furnished by its physician(s). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Lifetime Consent

If applicable, I request that payment of authorize Medigap or other secondary or tertiary benefits be made on my behalf to Jacob B. Goldstein, DPM for any services furnished by its physician(s). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents in the information needed to determine these benefits or the benefits payable for related services.

****** Signature of Beneficiary/Responsible Party _____Date: _____