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

Anastasia A. Samouilov, D.P.M
Foot and Ankle 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.

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

_____ _____

PATIENT NAME (Please Print) DATE:

_____

Parent of authorized representative (If applicable)

_____

SIGNATURE

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 $75.00 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 all Associates 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 co-pays, deductibles and non-covered services is expected at time of service. Your insurance company requires co-pays at time of service. A $10.00 surcharge is made in addition to all co-pays not paid at time of service. For your convenience, we accept MasterCard, Visa, Discover and American Express. 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. Custom made arch supports commonly referred to as “orthotics” require payment up front so as to cover our laboratory costs. If insurance is billed, then an appropriate refund will be given after your insurance company pays for them. Our policy is to collect one half of the total amount billed to your insurance company. This will be your deposit at the time the devices are ordered and the balance when the devices are fitted to your feet.

We participate with many insurance companies. While we are very knowledgeable concerning insurance matters, recent changes in healthcare require patients be proactive 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 our patients’ needs, we cannot answer those particular questions and it is recommended that you contact your insurance company concerning those issues.

Since we provide primary and specialty foot/ankle care, referrals are often required by our insurance coverage. **IT IS THE PATIENTS RESPONSIBILITY TO OBATIN A REFERRAL FOR OUR SERVICES.** If a referral is required and one is not available at the 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.** We do not bill any secondary insurance companies for any co-pays or any amounts less than $50.00. If your secondary insurance company does not pay us with-in 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 plus 12% annual interest. Returned check fees are $25.00.

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

PATIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE: _____

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