Dany Y Jabbour, D.P.M., F.A.C.F.A.S.

Practice of Podiatric Medicine and Surgery

91 Montgomery Street • Rhinebeck, NY 12572

Office: (845) 876-8637 • Fax: (845) 876-0218

www.rhinebeckpodiatry.com

PATIENT FINANCIAL REPSONSIBILITY STATEMENT

Thank you for allowing Rhinebeck Podiatry Services, Dr. Dany Y. Jabbour DPM, PLLC to provide your podiatric healthcare services. The medical services you are seeking imply a financial responsibility on your part. This responsibility obliges you to ensure payment in full for the services you receive at the time of your care. To assist in understanding that financial responsibility, we ask that you read and sign this form in its entirety. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, guardian, domestic partner, healthcare proxy, healthcare representative, etc) is financially responsible for your expenses or carries your insurance as the primary guarantor, please share this policy with them as it explains our practices regarding insurance billing, copayments, deductibles, co-insurance, and patient billing. Please read each area and initial each are that pretrains to you. By signing below and receiving medical services from Rhinebeck Podiatry Services you agree to the following:

1. **You acknowledge and agree the established policies and procedures of Rhinebeck Podiatry Services** including but not limited to this PATIENT FINANCIAL REPONSIBILITY STATEMENT, which a new PATINET FINANCIAL RESPONSIBILITY STATEMENT will be required on a yearly basis. _____ patient/authorized representative initials
2. If your insurance has changed you are required to notify our medical staff at the time of your visit. _____ patient/authorized representative initials
3. It is your responsibility to ensure that we are in network with all medical insurance plans which you are enrolled in. If you choose to retain services with our office and discover at the time of your visit that we are not in network with your medical insurance carrier you will be financially liable for your visit at the out of network cost as we will be unable to bill your insurance. _____ patient/authorized representative initials
4. You are responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for all deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or policies which are not otherwise covered by supplemental insurance at the time of your visit we will not send out patient bills. _____ patient/authorized representative initials
5. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or a referral by a Primary Care Physician (PCP) before receiving services at Rhinebeck Podiatry

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Services and you have not obtained the prior authorization or referral at the time of your visit. (ii) you receive services in excess of such prior authorization or referral are written for at the time of your visit; (iii) your health plan determines that the services your received at Rhinebeck Podiatry Services are not deemed medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Rhinebeck Podiatry Services or (v) you have chosen not to use your health plan coverage at the time of your visit we recommend you contact your carrier or plan provider directly. _____ patient/authorized representative initials

6. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any copays, co-insurance, deductibles, or other patient responsibility amounts at each visit. Your insurance card must be current and a copy on file for your insurance to be billed. If we do not have your current insurance card on file at the time of your visit or are unable to verify your insurance and eligibility for benefits you will be treated as a self-paid patient. As a self-paid patient as with patients who have insurance and a copay, co-insurance or deductible that must be met you are required to pay in full at the time of services we do not bill patients after service has been rendered. If after your visit you contact our office within 24 hours of the visit and furnish us with your insurance card, we may file a claim with your insurance carrier and if paid in full by your insurance carrier we will reimburse the amount you paid at the time of your visit with the exception of any copay, co-insurance or deductible your are required to meet under your insurance plan. If you are not prepared to make your co-payment, co-insurance, deductible or other patient financial responsibility at the time of your visit your visit will be rescheduled, and your will be required to pay a $50.00 fee at the time of rescheduling, we do not send out bills to patient's. _____ patient/authorized representative initials
7. By signing below, you authorize Rhinebeck Podiatry Services to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waving any obligation to pay, you assign Rhinebeck Podiatry Services, for application onto your bill for services, all of your tights and claims for the medical benefits to which you, or your dependents are entitled to under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care cost and for which payment may be available to cover the cost of the services provided to you. You authorized Rhinebeck

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Podiatry Services, staff and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-rays reports, MRI reports or other diagnostic and documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so can result in unpaid medical claims, and you will be responsible for the balance of the claim. Rhinebeck Podiatry Services does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans. _____ patient/authorized representative initials

8. I your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier process your claim, any remaining balance which is deemed patients responsibility set forth under your insurance plan will be the responsibility of the patient or the guarantor of the insurance plan and you will be sent a bill and will have 30 days to pay it in full before a late fee is assessed after 90 days of nonpayment on your account your account will be placed into active collections and interest at the rate of 1.5% will accrue each month. The patient will assume financial responsibility for the collection agency fees. If you make a payment which results in a surplus on your account, you authorize Rhinebeck Podiatry Services to apply the overpayment to any other account for which you are financially responsible for that may have an overdue balance which includes a member of your family or dependent account or any account for which you are considered Financially Responsible Party of. If there is no balance owed and there is a surplus on your patient account, the remaining surplus will be returned to the payor. _____ patient/authorized representative initials
9. If it is found at the time of your visit you have no co-insurance, co-pay, or deductible due but after submitting to your insurance carrier it is discovered there is a patient balance due. It is at that time you will be sent a billing statement. You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors of objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the office manager to address the problem. Any patient sent a bill that is deemed accurate has 10 business days from the date the bill is mailed to pay the balance due in full.

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After 90 days and the bill has not been satisfied the bill will be sent to a collection agency and the patient will assume financial responsibility for any collection agency fees as well as accrue interest on unpaid balances at the rate of 1.5% per month. All patient's receive from their insurance carrier an EOB (Explanation of Benefits) which explains the amount billed and the amount paid by your carrier as well as if a secondary carry was billed and paid along with the patient responsibility we strongly encourage all of our patients at Rhinebeck Podiatry Services to read their EOB to understand the services that have been paid by their plan carrier and what is deemed patient responsibility. _____ patient/authorized representative initials

Payments can be made by Check, Cash or Credit Card/Debit Card

1. **Payment by Check:** Checks should be made payable to Rhinebeck Podiatry Services or Dr. Dany Y. Jabbour DPM, PLLC. If payment is made by check and the check is returned or declined for any reason your account will be charged a surcharge of $26.58 which is the NSF (nonsufficient funds fee). This is the current 2022 bank rate fee and is subject to change based upon the NSF yearly. The NSF will then be added to your current patient balance. _____ patient/authorized representative initials
2. **Payment by Credit Card/Debit Card:** You may pay by credit card or debit card, including Visa, Master Card. Your payment with a credit or debit card may be made in person, by mail, by calling the office as well as left on file. If your charge is not accepted, you will be notified and any late charges or penalties resulting from the late receipt of any payment. Your information is used solely to process your payment. _____ patient/authorized representative initials
3. **Commercial Insurance (HMO, PPO, EPO, etc.):** All co-payment, co-insurance and deductibles amounts are due at the time services are rendered. If your insurance plan requires a referral or prior authorization from your primary care physician and you are responsible for presenting any referral or prior authorization at the time of your visit. Failure to present your referral or prior authorization will not permit us to bill your insurance company for the visit and your visit will be converted at that time to a self-paid visit. If you choose at that time not to be seen, you will be responsible at that time to pay a $50.00 cancellation fee. By signing below, you acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any services deemed to be non-covered or not authorized by the plan. _____ patient/authorized representative initials

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4. **Medicare:** Rhinebeck Podiatry Services is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and % co-insurance if there is no secondary carry or we do not participate with the secondary carrier. Medicare or secondary carriers do not cover some procedures or DME supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. Medicare has an annual patient deductible which starts at the beginning of the new year for all Medicare participants. The deductible is the patient's responsibility less the 20% once the deductible is met. What the patient needs to understand is that whichever doctor the Medicare patient sees first is the doctor who collects the patient deductible, this does include Rhinebeck Podiatry Services. By signing below, you request that payment of authorized Medicare benefits be made on your behalf to Rhinebeck Podiatry Services. _____ patient/authorized representative initials
5. **Medicaid:** We have opted not to participate with straight Medicaid. We do participate in Managed Care Medicaid programs, and you must present a valid insurance card at the time of registration and prior to the time of service. Your status will be verified 24 hours before your appointment to ensure it is active. Without verification of coverage, you will be considered a self-paid patient and be responsible for the entire balance of your visit, if you opt to cancel your appointment at the time of your visit you will be responsible for a $50.00 due at that time. You are responsible for non-covered services, or any spend-down requirements associated with your individual coverage. _____ patient/authorized representative initials
6. **Worker's Compensation Cases:** Charges for services incurred as a result of a verified work-related injury will be treated as workers' compensation, and we will be the workers' compensation carrier as a courtesy. You must provide the necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier when the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due in full within thirty (30) days. _____ patient/authorized representative initials
7. **Third Party Liability Injuries:** We do not directly participate with any third party liability companies ie. Auto insurance companies, premises liability or other general liability claims. This means that you would be coming in for services with Rhinebeck Podiatry Services as a

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self-pay patient and we are unable to bill your medical insurance carry if such a claim exist. We will furnish you with a list of services supplied at the visit(s) as well as a summary of the bill and service(s) and cost of service(s) provider for you to submit to the necessary third party for reimbursement, this does not guarantee they will reimburse you for the services. _____ patient/authorized representative initials

8. **DME Supplies:** We do provide DME supplies which may or may not be covered under your insurance carrier. It is important that you know what DME services are covered under your insurance carrier. If your insurance covers DME supplies you will be financially responsible for any co-pay, co-insurance or deductible set forth by your insurance carrier. If your insurance carrier does not cover DME supplies you will become a self-paid patient for the DME supplies, of which 50% is due at the time the order is placed and is non-refundable if you do not pick up your DME supplies. _____ patient/authorized representative initials
9. **Patient NO SHOW/24 Hour Cancellation Policy:** Rhinebeck Podiatry Services requires a minimum 24-hour cancellation policy on all appointments. As we ensure we confirm all our patient appointments 24 hours in advance we ask if you need to cancel your appointment that you give us 24 hours' notice so we may give another patient who has an appointment further out the opportunity to come in. We understand there are rare cases that it is difficult to give 24 hours' notice, ie family emergency, inclement weather, or you have become ill, but we ask that you do your best to give us the courtesy of advance notice, so we can give courtesy to another patient who needs to be seen sooner. If you cancel two (2) consecutive appointments at the time you cancel the second appointment you will be billed a fee of $50.00 for not cancelling within a 24-hour period. Our staff at Rhinebeck Podiatry Services confirm all patient appointment's 24-hours in advance, unless it is on Friday or right before a holiday then it could be confirmed within several days of the appointment and is documented in the patient chart at the time the appointment is confirmed this includes leaving a message for the patient regarding their appointment on a home answering machine or cell phone voicemail, whichever has been the approved method of confirmation chosen by the patient. If the patient fails to show up to the appointment and has not called, then the patient will be sent a bill as per CMS (Center for Medicare/Medicaid Services)/Medicare Administrative Contractor Noridian Healthcare Solutions as well as commercial plans, we are allowed to bill the patient directly for not showing up for their scheduled appointment. The fee that will be sent to the patient will be $75.00 and will not

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be billed to Medicare but to you, the patient who will be responsible. _____
patient/authorized representative initials

By signing below, each of the undersigned acknowledges that: (i) have been provided a copy of **Rhinebeck Podiatry Services Patient Financial Responsibilities Statement;** (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or become due) to Rhinebeck Podiatry Services for the below Patient's care and treatment including co-payments, co-insurance and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the patient account; (v)regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (iv) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including collection agency fees associated with my account balance, court cost and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to the late payment charges and can adversely affect my credit report.

I further agree that a photocopy/faxed copy/photo or scanned copy of this Patient Responsibility Financial Statement should be as valid as the original.

Once I signed this agreement. Whether by original. Facsimile. electronic (PDF), scanned, or photo taken and emailed, I agree to all the terms and conditions contained herein and the agreement shall be in full force and effect.

_____ _____

Patient/Responsible Party/Patient Representative/Guardian Print Name Date

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_____ _____

Patient/Responsible Party/Patient Representative/Guardian Signature Date

_____ _____

Witness Print Name and Signature Date