OPTIMAL
ANKLE & FOOT
DR AFFAN AKHTAR

We at Optimal Ankle & Foot are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding on our payment policy.

1. MEDICARE PATIENTS: We would like you to understand that accepting assignment means that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% (co-insurance) of what Medicare allows. You are also responsible for service that you're supplemental/ secondary insurance does not cover.

2. All co-payments are due at the time of visit. The returned check fee is $45.00.

3. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.

4. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider. It is also your responsibility to ensure that our physician is in your insurance network.

5. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for appointments will be charged $25.00 cancellation fee. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time. Patient who fail to cancel a scheduled surgery will be charged a $100.00 cancellation fee.

6. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the state of New Jersey. Fees must be received prior to record delivery, the fee for these records are $25.00.

7. Administrative Services: There is a $25.00 charge for each Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability and letters for insurance authorization.

8. PATIENT REFUNDS: Please allow 60 days from the time your insurance company responds to a claim for your deposit refund to be processed. Refunds will be issued in the form of a paper check that will be mailed to your home address.

I, _____, have received, read, and understand the financial policy at Optimal Ankle & Foot.

_____ _____

Signature of Patient Date


1211 Hamburg Turnpike, Wayne NJ 07470
***Telephone:*** 973-692-1113
1060 Clifton Avenue 1st Floor, Clifton NJ 07013
***Telephone:*** (973) 692-1113

***To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.***

**Patient's Legal Name:** _____ **DOB:** _____

I HEREBY AUTHORIZE OPTIMAL ANKLE AND FOOT :

- ✓ Any of my medical information, including information about:
- ✓ Mental health diagnoses and treatment*
- ✓ My lab results
- ✓ My appointment times, dates, and reasons for the visit
- ✓ The medications I am taking

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to CHC Medical Records), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

**Signature:** _____
*This authorization will only expire if I cancel it in writing.*

Witness: _____ Date: _____

**A minor patient's signature is required for us to share information about care for conditions**

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# PAYMENT POLICY

The filing of insurance claims is a courtesy we extend to our patients. We are happy to assist you in billing most insurance companies. However, we must emphasize that your insurance is contract between you and your insurance company. We are not party to that contract.

Many of the services provided in this office are covered and paid by your insurance company. In cases where the service has not been paid, you will be personally responsible for the balance. If the patient is a minor, the person brings the minor to the office for treatment is responsible for payment of the bill.

## Payments for services are due at the time service is rendered.

We accept cash, checks and all Visa or MasterCard. To assist you in making payments if special circumstances arise, we would be happy to arrange an automatic debt payment schedule to facilitate regular agreed upon payments.

Account balances:

0-30 days --- no interest

31-60 days – interest accrues

90 days and over will be turned over to CFS, LLC

Signature: _____ Date: _____