SOUTH FLORIDA
FOOT & ANKLE CENTERS

www.sffac.com

Dr. Jonathan Cutler, DPM
Dr. Brett Fried, DPM
Dr. Joshua P. Daly, DPM, MBA
Dr. Jennifer Kazamias, DPM

Royal Palm Beach:
11412 Okeechobee Blvd.
Royal Palm Beach, FL 33411
Tel (561) 793-6170
Fax (561) 795-3683

Lake Worth:
3618 Lantana Rd.
Suite 102
Lake Worth, FL 33462
Tel (561) 967-4999
Fax (561) 967-2465

Palm Beach Gardens:
3375 Burns Rd.
Suite 107
Palm Beach Gardens, FL 33410
Tel (561) 691-4682
Fax (561) 624-7084

Belle Glade:
1100 S. Main Street
Belle Glade, FL 33430
Tel (561) 993-9968
Fax (561) 996-5970

Boynton Beach:
6699 Boynton Beach Blvd.
Suite 2B
Boynton Beach, FL 33437
Tel (561) 793-6170
Fax (561) 795-3683

Release of Medical Records/Information

This office is HIPAA compliant. We make every effort to protect your privacy. We feel it is important that you understand your patient rights to confidentially. If you have any concerns please fell free to discuss them with our manger.

Medical Records Information Release

I understand that by signing this document I am authorizing the release of my medical information to my insurance carrier(s) needed for this or any related medical insurance claim. I authorize any holder of medical information or other information about me to release to the social security administration and the health care financing administration, it's intermediaries, carriers and information needed for this or any related claim.

_____
Initials

Medical Record Release to Hospitals/Physicians

I, the undersigned, authorize the release of my medical information to other physicians needed to provide my care. I further authorize release to hospitals and/or healthcare facilities as pertaining to my care. I understand that my records may be faxed to hospitals and/or physicians and that all reasonable efforts will be made to maintain confidentially.

_____
Initials

Medical Records Release to Family

I authorize South Florida Foot and Ankle Center to release information pertaining to my illness and or treatment to: _____ . I authorize South Florida Foot and Ankle Center to leave medical information on my answering machine. I also authorize information to be given to my spouse.

_____
Initials

Patient Rights to Confidentiality

I understand that South Florida Foot and Ankle Center's office complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or medical facility; however, this request must be made in writing. I understand that by law this office may only release medical records that were generated by South Florida Foot and Ankle Center. We cannot release medical records from any other physician, hospital or facility. I agree to accept responsibility for a copying fee as provided by Florida statues. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to this practice or to the Secretary of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

_____
Initials

_____
Print Name

_____ _____
Signature **Date**

SOUTH FLORIDA
FOOT & ANKLE CENTERS
www.sffac.com

Dr. Jonathan Cutler, DPM
Dr. Brett Fried, DPM
Dr. Joshua P. Daly, DPM, MBA
Dr. Jennifer Kazamias, DPM

Royal Palm Beach:
11412 Okeechobee Blvd.
Royal Palm Beach, FL 33411
Tel (561) 793-6170
Fax (561) 795-3683

Lake Worth:
3618 Lantana Rd.
Suite 102
Lake Worth, FL 33462
Tel (561) 967-4999
Fax (561) 967-2465

Palm Beach Gardens:
3375 Burns Rd.
Suite 107
Palm Beach Gardens, FL 33410
Tel (561) 691-4682
Fax (561) 624-7084

Belle Glade:
1100 S. Main Street
Belle Glade, FL 33430
Tel (561) 993-9968
Fax (561) 996-5970

Boynton Beach:
6699 Boynton Beach Blvd.
Suite 2B
Boynton Beach, FL 33437
Tel (561) 793-6170
Fax (561) 795-3683

Financial Policy

Patient Name

Payment of Benefits to the Physician/Provider

I, the undersigned, understand that South Florida Foot and Ankle Center has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance after Medicare and or my health insurance payment which is paid to South Florida Foot and Ankle Center. I understand that I am financially responsible for any charges not covered by authorization. If I fail to give updated or current information and the claim is denied I will be totally responsible for the entire balance.

Signature **Date**

Method of Payment

Payment is required at the time the service is rendered. South Florida Foot and Ankle Center is a participating provider with Medicare, BCBS, and many other "PPO" and "HMO" plans. Please check with our receptionist to see if we participate with your insurance plan. Preferred Provider (PPO) and (HMO) medical claims will be filed automatically by our office. Please present your insurance card(s) to our receptionist for photocopying and benefit eligibility verification. You will be responsible for any copay or coinsurance amount at the time of your visit. In the event your check is returned for any reason, your account will be charged $35.00. In the event it is necessary for your account to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. We file your medical insurance as a courtesy. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the account may be referred to a collection agency or attorney.

For your convenience, we accept MasterCard, Visa, American Express, Discover, as well as cash. We are no longer accepting checks.

If you are scheduled for an appointment and need to cancel please contact our office, if you should fail to give 24 hours notice you will be charged a $20.00 fee. If you were scheduled for a diagnostic test and failed to comply with the cancellation policy the fee is $50.00- these fees are due on your next scheduled visit.

Thank you for taking the time to review our financial policy. Your cooperation is greatly appreciated. If you should have any questions, or require any assistance, we will be pleased to be of service.

I have read this financial policy and understand my rights and responsibilities.

Signature **Date**