

Missed Appointment Policy

Updated March 29, 2021

In order to keep our fees as low as possible, Associates in Podiatry, Inc. (AIP) must very carefully control costs. When patients fail to show up for their appointments, we still pay our staff even if they don't have a patient to treat, and our other patients who need appointments are unable to receive the care they require if we don't have enough notice to be able to fill the empty appointment time. Our policies on late arrivals, cancellations and no-shows are based on experience and are a critical part of being able to continue operating our nonprofit dental Clinic.

A missed appointment is defined as (a) an appointment that you do not show up for or (b) an appointment that you provide *less than 24-hour notice to cancel or reschedule.*

Please Confirm Your Appointment: AIP will contact you multiple times prior to your appointment by text, email and telephone. You must reply to one of these contacts to confirm your appointment. It is as easy as clicking "confirm" and "send." Please note: PRDC has voicemail. If it is after normal business hours and you need to cancel, reschedule, or confirm, you may leave a voicemail message at (937) 399-8011

If you have not confirmed your appointment 24 hours prior to your appointment, AIP reserves the right to reschedule you.

Late Arrivals: Please keep in mind that AIP maintains a very full schedule. Even one patient running late can impact the schedule of the entire Clinic. Please call us and let us know if you are running behind so we can manage accordingly.

If you are more than 15 minutes late for your appointment and we haven't heard from you, AIP reserves the right to take another patient in your appointment slot.

Cancellations: If you need to cancel or reschedule your appointment, please give AIP at least a 24-hour notice so we have time to fill the appointment slot with another patient.

If you do not give a 24-hour notice, it is considered a missed appointment.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a **\$35 fee** for any appointment cancelled or rescheduled within 24 hours of the scheduled time. Additionally, there may be a **\$35 fee** if you miss a scheduled appointment. If you miss 2 or more appointments, you may be required to pay a \$50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

Consequences of multiple missed appointments for our Medicaid patients: All missed appointments will be reported to Medicaid. The second missed appointment within six months will result in a 30 day delay before you can reschedule so we can give other patients the opportunity to schedule time with

the dentists. The third missed appointment within six months will result in your no longer being able to make advance appointments, although you may still make same-day appointments. Please call us on a day you can come in and we will determine if we can make room for you on our schedule.

I understand Associates in Podiatry Appointment Policy. I agree to confirm my appointments at least 48 hours ahead of time. I understand all missed appointments will be reported to Medicaid.

Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____



Associates in Podiatry

Dr. Donald LeMelle, DPM Dr. Jeff Cain, DPM

Board Certified Podiatric Surgeons

Orthotic Codes for Insurance

You have been informed that you need orthotics by **Dr. Cain** or **Dr. LeMelle**. In order for you to receive orthotics you will need to call your insurance company to determine the percentage the insurance company pays toward the cost of orthotics. In addition, you will need to ask your insurance company if you have met your deductible for this year. If you have not met your deductible, the cost of orthotics will be an out of pocket expense for you.

When calling your insurance company, you will be asked to provide the medical diagnosis given to you by **Dr. Cain** or **Dr. LeMelle**, for your condition and treatment or procedure you will be receiving for the condition. Your insurance company representative will be asking for ICD and CPT codes. The codes are circled below.

ICD codes

Achilles, Bursitis, Tendonitis	Left: M76.62, Right: M76.61
Capsulitis, Tendonitis	M77.9
Metatarsalgia	Left: M77.42, Right M77.41
Enthesopathy	Left: M77.52, Right M77.51
Pain in foot/limb	Left: M79.672, Right M79.671
Plantar fasciitis	M72.2
Equinus Coag.	M21.6X9
Calcaneal spur (w/symp)	Left: M77.32, Right M77.31

CPT codes

L3000 Left Foot
L3000 Right Foot

If after calling your insurance company, you have made the decision to have orthotics made for you please call the office to schedule an appointment: **937-399-8011**

There is a non-refundable charge of \$65.00 due on the day you are casted. This fee covers the costs of casting supplies and lab fees. If you are unable to pay the fee the day of casting, you will be rescheduled.



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Financial Policies

Effective May, 2016

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: *All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE.* This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier, however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

PHYSICIAN PHONE CALLS: Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. **Any custom durable medical equipment item may not be returned for any reason.**

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to state regulations regarding copy fees. You will bear complete financial responsibility for any fee(s) incurred.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a \$25 fee for any appointment cancelled or rescheduled within 24 hours of the scheduled time. Additionally, there may be a \$25 fee if you miss a scheduled appointment. If you miss 2 or more appointments, you may be required to pay a \$50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a 35% fee will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover. An additional \$25.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Dr. Cain and Dr. LeMelle for medical services provided. I agree to pay Dr. Cain and Dr. LeMelle any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Dr. Cain and Dr. LeMelle all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE.** I hereby authorize the doctor to release all information necessary to secure payment of

benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ **Signature:** _____

If patient is under 18, please complete the following for the *FINANCIALLY RESPONSIBLE PARTY*:

PRINT Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** _____



Associates in Podiatry
415 W. Harding Rd. Springfield, OH. 45504
Dr. Donald LoMello, DPM Dr. Jeff Cain, DPM

Do I Need a PADNET Test? Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, blood pressure that is difficult to control, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help to determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Print Name Here: _____ **DOB** _____

Please circle all that apply to you: Diabetes Current Smoker Former Smoker High Blood Pressure

1. Do you have a history of cardiovascular disease or diabetes, and experience any pain or swelling at rest in your lower legs or feet? **Please circle : Yes or No**
2. Do you have a history of cardiovascular disease or diabetes and experience any leg, foot or toe pain that often disturbs your sleep? **Please circle : Yes or No**
3. Do you have an ulcer on your thigh, calf, ankle, foot or toe that is slow to heal? **Please circle : Yes or No**
4. Do you have diabetes and unusual hair loss or skin discoloration in your legs? **Please circle : Yes or No**
5. Do your fingers or toes feel numb or cold in response to temperature changes or stress? **Please circle : Yes or No**
6. Have you suffered a severe injury to your leg(s) or feet? **Please circle : Yes or No**
7. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? **Please circle : Yes or No**
8. Have you had blockages in your coronary or heart arteries? **Please circle : Yes or No**
9. If you have ever had a blood clot, please answer the following:
 When did the blood clot occur? _____
 Where was it located in the body? _____
 Are you currently taking any blood thinners? _____
 What caused the blood clot? _____
 Other comments or Notes: _____

Patient Signature: _____

Date: _____

Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: _____ Date of Birth: _____

I certify that I am the parent and/or legal guardian of _____
(Name of child)

I authorize _____ to bring my child to office visits with Dr. _____
(name of person bringing child to office) *(name of physician)*

I authorize the minor child named above to come alone to office visits with Dr. _____
(name of physician)

and I consent to the examination and/or treatment of my child.

This authorization:

is effective on _____

is effective from _____ to _____

is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home phone number _____

Office phone number _____

Cell phone number _____

Other phone number _____

I reserve the right to revoke this authorization at any time by writing to the above-named physician.

Parent/Guardian Signature: _____

Date: _____

Associates in Podiatry

Payment Policy & Privacy Practices

Notice of Privacy Practice

Health Information Use and Disclosure. We will use and disclose your health information expressly for the following purposes: to treat you, to assist other healthcare providers in treating you, to allow insurance companies to process claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except for the aforementioned reasons, we will not use or disclose your health information without your written authorization. We reserve the right to change this notice and will post a copy of the current notices in effect in our facility.

Additional Disclosure Authority. In addition to the allowable disclosures described in the State of OH Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below. This can include: any/all members of immediate family, spouse, employer, school, or any other person.

Name & Relationship to Patient

Name & Relationship to Patient

Name & Relationship to Patient

Name & Relationship to Patient

Patient Rights

As our patient, you have the following rights:

- ◆ To have access to inspect and/or obtain a copy of your health information that may be used to make decisions about your care.
- ◆ To receive an accounting of certain health information disclosures we have made.
- ◆ To request restrictions pertaining to how health information is used and disclosed for treatment payment or health operations.
- ◆ To request that we communicate with you in confidence; in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work.
- ◆ To request that we amend your health information if you feel medical information we have about you is incorrect or incomplete. To receive notice of our privacy practices by requesting a paper copy at any time.

Acknowledgement of Payment Policy/Notice of Privacy Practices

Payment Policy

I have read and fully understand the payment policy of Associates in Podiatry. I acknowledge my rights and responsibilities and agree to act in accordance with the policy set forth. I understand that if I fail to comply with the policy, Associates in Podiatry reserves the right to dismiss me from the practice.

Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read and understood the Notice.

Signature of patient or responsible party if patient is under 18

Date

Assignment & Release

Insurance Authorization

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and sign directly to Associates in Podiatry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Associates in Podiatry for any services furnished me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release for the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, 20%, and non-covered services. Coinsurance, 20% and the deductible are based upon the charge determination of the Medicare carrier

Signature of patient or responsible party if patient is under 18

Date

Consent - I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my conditions. I give permission to acquire audiovisual documentation for diagnostic and treatment purposes. I understand that other practitioners such as surgical assistants, surgical residents, physician assistants, nurses and other staff may assist the doctor in performing my treatment and I give my permission for them to do so.

Signature of patient or responsible party if patient is under 18

Date

FOR OFFICE USE	
Reviewed by: _____	Date: _____

I understand that it is my responsibility to inform the doctor's office if there is any change in my health insurance information and I acknowledge I was provided with a copy of the Notice of Privacy Practices. I understand and accept it's terms:

Print Name: _____

Signature: _____

Associates in Podiatry

(937)399-8011 • (Springfield)

415 Harding Road Springfield, Ohio 45504

Patient Information

Name: _____ Date of Birth: _____ Age*: _____

Address: _____ City, State: _____ Zip: _____

Primary Phone Number: _____ Home Cell Work

Secondary Phone Number: _____ Home Cell Work

SSN: _____ Email: _____

Marital Status: Single Married Divorced Separated Widowed

Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

Shoe Size: _____
Height: _____ Weight: _____

*If patient is under 18, we will need the following information from a parent or guardian:

Name: _____ Date of Birth: _____ SSN: _____

Relationship to Patient: _____ Phone (if different from patient): _____

Address (if different from patient): _____

Referral Information

Who may we thank for referring you?

Physician _____

Insurance Plan _____

Family/Friend _____ Yellow

Book Google Internet Walked

By/Drove By Former Patient

Other _____

Primary Care Physician

To facilitate sharing of information related to your care, please provide the following information.

Primary physician _____

Office Phone Number _____

Date of Last Visit? (approx) _____

Do You Reside in Hospice? Yes No

Do You Reside in a Nursing Home? Yes No

Name of Residence: _____

Insurance Information

Primary Insurance Name: _____ Identification #: _____

Group #: _____ Who is Responsible for this Account? Self Spouse Parent

Cardholder Info: Name: _____ Date of Birth: _____ SSN: _____

Secondary Insurance Name: _____ Identification #: _____

Group #: _____ Who is Responsible for this Account? Self Spouse Parent

Cardholder Info: Name: _____ Date of Birth: _____ SSN: _____

Emergency Contact

Name: _____ Relationship: _____

Primary Phone Number: _____ Home Cell Work

Secondary Phone Number: _____ Home Cell Work

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Additional Disclosure Authority. In addition to the allowable disclosures described in the State of OH Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below This can include: any/all members of immediate family, spouse, employer, school, or any other person.

Name & Relationship to Patient

Name & Relationship to Patient

Name & Relationship to Patient

Name & Relationship to Patient

Patient Rights

As our patient, you have the following rights:

- To have access to inspect and/or obtain a copy of your health information that may be used to make decisions about your care.
- To receive an accounting of certain health information disclosures we have made.
- To request restrictions pertaining to how health information is used and disclosed for treatment payment or health operations.
- To request that we communicate with you in confidence; in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work.
- To request that we amend your health information if you feel medical information we have about you is incorrect or incomplete. To receive notice of our privacy practices by requesting a paper copy at any time.

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Signature of patient or responsible party if patient is under 18

Date

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Insurance Authorization

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I request that payment of authorized Medicare benefits be made on my behalf to Associates in Podiatry for any services furnished me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release for the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, 20%, and non-covered services. Coinsurance, 20% and the deductible are based upon the charge determination of the Medicare carrier.

Signature of patient or responsible party if patient is under 18

Date

Consent - I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my conditions. I give permission to acquire audiovisual documentation for diagnostic and treatment purposes. I understand that other practitioners such as surgical assistants, surgical residents, physician assistants, nurses and other staff may assist the doctor in performing my treatment and I give my permission for them to do so.

Signature of patient or responsible party if patient is under 18

Date

FOR OFFICE USE

Reviewed by: _____

Date: _____

I understand that it is my responsibility to inform the doctor's office if there is any change in my health insurance information, and acknowledge I was provided with a copy of the Notice of Privacy Practices. I understand and accept these terms.

Print Name: _____

Signature: _____

**If the patient is under 18, please have the financially responsible party (guardian) complete the following section:

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Do you have any allergies: _____ NO _____ YES, please list below

Signature: _____ Date: _____