

Dr. Robert G. Rosen

Brevard Podiatry

DPM, FACFAS, CWS*

*Board Certified in Surgery by American Board of Podiatric Surgery

*Fellow of College of Certified Wound Care Specialist

ASSIGNMENT OF BENEFITS & FINANCIAL POLICY

I understand that it is my sole responsibility to inform Brevard Podiatry, Dr. Robert G. Rosen and/or assigns (referred to as "Practice") of any changes in my insurances coverage. I authorize my insurer to make payments directly to my doctor. A copy or fax of this authorization may be used in place of the original and shall apply to all bills submitted by the Practice. I authorize my doctor to release any information regarding my examination or treatment to my insurer.

I understand and agree that the Practice will prepare forms to help me obtain benefits from my insurer but that I will be personally liable for my doctor bills unless I am notified in writing by the Practice to the contrary. I agree to make payment in full on all bills within 30 days of services rendered. I understand that any payment, which is over 30 days or more delinquent will be subject to late fees of \$20, plus after such date interest at a rate of 1.5% per month (or the highest percentage allowed by law) on the unpaid balance. If my doctor does not initially charge any late fees and/or interest I agree that this does not limit their ability to charge these fees in the future. In addition to my outstanding balance, plus fees and accrued interest I agree to pay all collection agency, credit bureau and/or attorney's fees and costs incurred in any attempt to collect the amount due.

I understand that it is my responsibility to furnish the Practice with my most current insurance information. I also understand that if my insurance coverage changes that I must immediately inform the Practice. Failure to do so may result in a significantly higher patient responsibility. I also understand that if the Practice does not participate with my current or future medical coverage I will be personally responsible for all charges incurred by myself.

I understand there will be a charge of \$0.50 per page for photo copies of medical records and a \$10.00 charge for any x-ray films. All originals **MUST** remain with the Practice as part of my permanent medical record for duration not less than that prescribed by law. I agree that if copies of my records are desired I will provide a written request, minimum of 72 hours advance notice and the pre-payment of \$0.50 per page and \$10.00 per x-ray film.

I understand that if I do not cancel my appointment within a 24 hour period with the Practice or do not show up for my appointment that I will incur a \$30.00 charge to my account.

Brevard Podiatry, Dr. Robert G. Rosen, DPM, take the confidentiality of our patients very seriously. Unless I inform you in writing to the contrary I agree to have Brevard Podiatry, Dr. Robert G. Rosen, DPM, call to remind me or any person or answering machine at the number I provide of my next appointment or missed appointments.

Also, from time to time Brevard Podiatry, Dr. Robert G. Rosen, DPM, will send announcements, newsletters, reminder cards and other educational information to you by mail. Brevard Podiatry, Dr. Robert G. Rosen, DPM will not discuss diagnosis, treatment, prognosis or test results with anyone other than the patient without permission from the patient.

Printed Name

Signature

Date