Birmingham FootCare Specialists
600 N OLD WOODWARD AVE STE 202 | BIRMINGHAM MI, 48009 | (248) 594-3338

Written Financial Policy

Thank you for choosing Birmingham FootCare Specialists. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Birmingham Foot Care Specialists requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds for treatments over $75.00. For plans requiring multiple appointments, alternative payment arrangements may be provided.

We also offer in-house financing for treatments over $300.00.

For patients with insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Please note, according to a Fraud Alert issued by the U.S. Department of Health and Human Services in 1998, it is against the law to waive deductible or co-insurance charges.

A fee of $60.00 is charged for patients who miss more than 2 appointments in a calendar year without 1-hour notice.

Birmingham Foot Care Specialists charges $35.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

____
Patient, Parent or Guardian Signature Date

____
Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Birmingham FootCare Specialists
Peter E. Schaffer, D.P.M
600 N. Old Woodward Suite 202
Birmingham, MI 48009
248.594.3338

CHIEF PROBLEM ____

____
FIRST NAME LAST NAME

BIRTH DATE____/____/______ AGE ______

HOME ADDRESS _________________________ CITY __________________ STATE ___

ZIP CODE ________ EMPLOYER __________________ OCCUPATION __________________

HOME # (____) _____-_______ CELL# (____) _____-________ WORK# (____) ______-_______

EMAIL ______________________________________
(List email if you would like to register for online medical records access)

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOW OR OTHER

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD LIFE PARTNER

ARE YOU DIABETIC? Y OR N ***IF YES, ARE YOU INSULIN DEPENDENT? Y OR N

ALLERGIES? Y or N / IF YES LIST:____

____

CURRENT MEDICATIONS/VITAMINS:____

____

____

EMERGENCY CONTACT________________________________PHONE NUMBER______________________

HOW DID YOU HEAR ABOUT US? (CIRCLE ONE)

DOWNTOWN PUBLICATION PHYSICIAN INTERNET HOUR MAGAZINE SIGN PATIENT

OTHER ________________________

DUE TO THE MANY CHANGES IN INSURANCE POLICIES, IT IS NO LONGER AN EASY TASK TO INTERPRET EACH INDIVIDUAL POLICY ALTHOUGH WE TRY TO STAY AWARE OF THESE CHANGES, IT IS NOT ALWAYS POSSIBLE. THEREFORE, WE URGE YOU, AS THE PATIENT TO PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO ANY TREATMENT OR SURGERY. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE. FAILURE TO COMPLY WITH THIS SUGGESTION COULD RESULT IN YOU, THE PATIENT, BEING RESPONSIBLE FOR ALL COSTS INCURRED. PLEASE REMEMBER YOUR INSURANCE POLICY IS BETWEEN YOU AND YOUR INSURANCE COMPANY AND NOT WITH THE INSURANCE COMPANY AND YOUR DOCTOR.

SINCERELY,
BIRMINGHAM FOOTCARE SPECIALISTS.

______________________________ ______________________

PATIENT/GUARDIAN'S SIGNATURE DATE

BIRMINGHAM FOOTCARE SPECIALISTS

DR. PETER SCHAFFER, DPM

PLEASE INITIAL EACH LINE

_______YES, I WISH TO HAVE PETER SCHAFFER, DPM PROVIDE FOOT CARE AS NEEDED AND IN ACCORDANCE TO ANY GUIDELINES SET FORTH BY THE INSURANCE COMPANY, IF APPLICABLE. IT IS MY RESPONSIBLIY TO KNOW MY INDIVIDUAL COVERAGE. FAILURE TO COMPLY WITH THIS SUGGESTION COULD RESULT IN ME, THE PATIENT, BEING RESPONSIBLE FOR ALL COST INCURRED.

* REMEMBER YOUR INSURANCE POLICY IS BETWEEN YOU AND YOUR INSURANCE COMPANY AND NOT WITH THE INSURANCE COMPANY AND YOUR DOCTOR.

______DR. SCHAFFER'S STAFF OR HIS AGENTS MAY CONTACT YOU BY TELEPHONE AT ANY TELEPHONE NUMBER ASSOCIATED WITH YOUR ACCOUNT, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO YOU. WE MAY ALSO CONTACT YOU BY SENDING TEXT MESSAGES OR E-MAILS, USING ANY EMAIL ADDRESS YOU PROVIDE TO USE. METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICIAL VOICE MESSAGES AND/OR USE OF AN AUTOMATIC DIALING DEVICE, AS APPLICABLE. I HAVE READ THIS DISCLOSURE AND AGREE THAT BFCS MAY CONTACT ME/US AS DESCRIBED ABOVE.

_________________________________ __________

SIGNATURE OF PATIENT/GUARDIAN DATE

_________________________________ __________

SIGNATURE OF WITNESS DATE

HIPAA Privacy Consent/Authorization Form

(Required by Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

PETER SCHAFFER, DPM
BIRMINGHAM FOOTCARE SPECIALISTS
600 N. OLD WOODWARD AVE, SUITE 202 BIRMINGHAM, MI 48009

Health Insurance Portability and Accountability Act requires that all medical provides insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Birmingham Footcare Specialists requests that each patient sign this consent form which allows share and protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative: _______________________Date:____________
Name of Patient or Representative: _________________________Date of Birth: ____________

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request the results of tests and procedures. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow Birmingham Footcare Specialists to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Birmingham Footcare Specialists to release my laboratory/radiology results and reports to the following individuals:

1.______________________Relationship to patient: ___________________Date:__________
2.______________________Relationship to patient: __________________Date: __________
PATIENT NAME: ______________________ PATIENT SIGNATURE: _________________________

Authorization to Leave with Household Members/Answering Machine

From time to time it is necessary for representatives of Birmingham Footcare Specialists to leave message for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call BFCS regarding an issue or concern. At no time will a representative of BFCS discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: ____
Patient Signature: _______________________________________ Date: ________________________