Greater Hartford Podiatry 580 Cottage Grove Rd Suite 203 Rafael González, DPM LLC Bloomfield, CT 06002 Phone: (860) 263-7999 Fax: (860) 216-0664

**PATIENT RESPONSIBILITY STATEMENT**

Your signature below forms a binding agreement between Greater Hartford Podiatry (GHP - the provider of medical services) and the patient who is receiving medical services, or the responsible party for minor patients (those patients under 18 years old). Responsible party is the individual who is financially responsible for payment of medical bills.

**All charges for services rendered are DUE and PAYABLE at the time of service.**

**MEDICAL INSURANCE**: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, **You are responsible** if your insurance company declines to pay for any reason.

The patient or person signing on behalf of the Patient as the responsible party must:

• Inform GHP of the current address and phone number for the patient and the

responsible party.

• Present all current insurance cards prior to each office visit.

• Verify at each visit that the information is current.

• Pay any required balance (including copay) at the time of the visit.

• Pay any additional amount owing within 30 days after being sent a statement from our office.(When GHP receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

**Returned Check Policy**

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the patient’s responsible party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, GHP will send out a letter to notify the responsible party of the returned check. If a response is not made within 15 days from the letter date by the patient or the responsible party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

**Non-Payment on Account**

All amounts owed are to be payed within 30 days of statement being issued. If amount is not paid collection proceedings will occur for any outstanding balance.

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient’s responsible party, understands that GHP has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment

**PATIENT RESPONSIBILITY STATEMENT (CONT.)**

for services rendered. The patient, or the patient’s responsible party, understands that they are

responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

**Late or absent for scheduled appointment**

Patient or responsible party shall be responsible to arrive on time for all scheduled appointments. We ask that you arrive 15 minutes early to conclude all necessary paperwork. If said patient is

**10** **minutes late** to their scheduled appointment time **it will be cancelled** and patient will have to reschedule for another time.

**If PATIENT** or **RESPONSIBLE PARTY does not show up/or call to cancel for scheduled appointment; and/or consistently misses appointments the patient could incur the cost of a $40 OFFICE VISIT FEE which is not covered by holders insurance.**

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. **Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms to be seen in the office.**

Patient Name (Please Print)

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Patient Signature

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Responsible Party (Please Print)

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Responsible Party Signature

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