SAVA PODIATRY AND WELLNESS CENTERS

Adult & Children's Foot Care | Foot & Ankle Surgery | Sports Medicine | Regenerative Medicine

PATIENT INFORMATION AND HISTORY

FIRST NAME:_____LAST NAME:_____MIDDLE____

MALE / FEMALE / OTHER / PREFER NOT TO RESPOND STATUS: MAR / SING / DIV / WID

BIRTHDATE: _____AGE: _____SOC SEC#: _____

PHONE#(H):_____(W):_____CELL: _____

E-MAIL: _____

HOME ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL: _____

RELATIONSHIP:_____ EMERGENCY CONTACT:_____

PHONE#_____RELATIONSHIP:_____

PRIMARY PHYSICIAN: _____PHONE#_____

DATE OF LAST VISIT TO PRIMARY:_____DIABETIC: YES / NO / UNKNOWN

PHARMACY:_____PHONE#_____

Primary Insurance Company: _____

Secondary Insurance Company: _____ Primary Insurance Policy #: _____

Secondary Insurance Policy #: _____ Relationship to Patient: ___ Self ____Spouse _____Parent

How did you learn about our practice? Yelp / Sava Podiatry Website / Insurance Website / Google / Zocdoc / Referral (who?)_____ / Other_____

What is your Primary reason for today's visit: _____

Side: LEFT / RIGHT / BOTH Area: TOP /BOTTOM Pain Level 1 to 10:_____

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Mark where the pain is occurring:

left foot

right foot

DATE PROBLEM STARTED: _____ Work related? Yes/ No **Car accident?** Yes / No

History of trauma? Yes / No_____

What kind of pain is it? Burning / Throbbing / Achy / Sharp / Dull / Numb / Other: _____

Have you attempted treatment? Yes / No Describe: _____

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Sava Podiatry and Wellness Centers immediately of any changes to the above information and annually upon the office's request.

Signature of Patient/Guardian: _____

PRINT NAME: _____ **Relationship:** _____**Date**: _____

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Past Medical History

Do you have any problems with, now or in the past, any of the following, please check:

- ☐ Diabetes
- ☐ Stomach Ulcers
- ☐ Bleeding Disorders
- ☐ High Blood Pressure
- ☐ Liver Trouble
- ☐ Osteoporosis/Weak Bones
- ☐ Skin Ulcers
- ☐ Dermatitis
- ☐ Leg Cramps
- ☐ Cancer
- ☐ Kidney Trouble
- ☐ RSD/CRPS
- ☐ MRSA Infection
- ☐ Circulation Problems
- ☐ Asthma
- ☐ Arthritis
- ☐ Substance Abuse
- ☐ Stroke
- ☐ Blood Clots
- ☐ Heart Trouble
- ☐ Nerve Disorders
- ☐ Neuropathy
- ☐ Skin Rashes/Fungus
- ☐ Autoimmune Problems
- ☐ Hepatitis
- ☐ Fractures/broken bones
- ☐ Anesthesia Problems
- ☐ Bleeding Tendency
- ☐ Gout
- ☐ Blood Disorder
- ☐ Chest Pain/Palpitations
- ☐ Anemia
- ☐ Lower Back Issues
- ☐ No Known Problems
- ☐ Other_____

If YES to any of the above, or anything not mentioned above, please explain:_____
_____

Are you currently on any medications/vitamins/supplements? Yes / No Name/Dose:
_____

Drug Allergies: PENICILLIN / NOVOCAINE / CODEINE / ASPIRIN / TAPE / IODINE/ LATEX / SHELLFISH / IV DYE / NONE / OTHER: _____

Previous Surgery (with dates):_____

List relationship to you of family members who have had:

Diabetes_____ Arthritis_____
Stroke_____ Cancer_____ Foot problems_____ Heart Attack_____ High Blood Pressure_____ Birth Defects_____

Social History

Occupation_____ Are you currently working? Yes / No / Student

Do you drink alcoholic beverages? Yes / No If yes, how much/week? _____

Do you smoke? Yes / No If yes, how much/day? _____ How many years? _____ If you quit smoking, when did you do so? _____
Do you use any drugs for non-medical purposes? Yes / No If Yes, what type? _____ Are you or could you be pregnant? Yes / No

Signature of Patient/Guardian: _____ Date: _____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable Federal and State laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your protected health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health information that may occur. These examples are not meant to be exhaustive, but to describe the types and uses and disclosures that may be made by our office.

The doctors at Sava Podiatry and Wellness Centers. are committed to maintaining the confidentiality of their patient's protected health information (PHI). We emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform her job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard confidentiality of PHI. All existing confidentiality protections concerning PHI apply to telemedicine consultations.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Telemedicine Consultations: Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your PHI may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken. The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.

Business Associates: A business associate is an individual or entity under construct with us to perform or assist us in a function or activity which necessitates the use of medical information for example: a medical record copy service, consultants, accountants, lawyers, medical transcription and third party billing companies. Federal law provides that we may use your PHI without further specific noticed to you or written authorization by you in the following categories:

Payment: Your protected health information will be used, as needed to obtain payment for your health care services, This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training students, licensing, and conducting or arranging for other business activities.

For Example, we may use a sign in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products and services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by laws as described below.

You may give us written authorization to use your protected health information or to use your protected health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health information except as described in this notice.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close family friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose you protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose you protected information, if we believe that the use of disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required By Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for the purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may use or disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Other Uses and Disclosures: In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by applicable law.

Uses and Disclosures Which Require Written Authorization: As required by applicable law, all other uses and disclosures of your Health Information (not described above) will be made only with your written permission, which is called an Authorization.

Psychotherapy Notes: If we maintain psychotherapy notes, we must obtain your Authorization for any use or disclosure of such psychotherapy notes, except to carry out the following treatment, payment, or healthcare operations. (a) use by the originator of the psychotherapy notes for treatment; (b) use or disclosure by us for our own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (c) use or disclosure by us to defend ourselves in legal action or other proceeding brought by you.

Certain Marketing Purposes: If we receive financial remuneration in exchange for making a marketing communication, we must obtain your Authorization for any use or disclosure of Health Information other than face- to-face communication made by us to you, or for a promotional gift of nominal value provided by us.

Sale of Health Information: We must obtain your Authorization for any sale of your Health Information and such Authorization will state that the disclosure will result in our receiving remuneration.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access of your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we may charge you a reasonable fee for copying costs, postage, if you want the copies mailed to you. If you prefer, we will prepare a summary of explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for full explanation of our fee structure.

Right to Receive Written Notification of Breach of your Unsecured Health Information: You have the right to receive written notification of a breach of your unsecured Health Information if it has been accessed, used, acquired, or disclosed in a manner not permitted by the Privacy Rules. We will provide this notification by first-class mail or, if necessary, by such other substituted forms of communication allowable by law or you may request in writing to receive a notification of a breach by electronic mail.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. If you request this list more than once in a 12 month period, we may charge a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on the use and disclosure of your health information for treatment, payment and healthcare operations. We will consider, but do not have to agree to such requests. However, we must agree to restrict a disclosure of Health Information about you to a health plan if (a) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law; and (b) the Health Information pertains solely to a healthcare item or service for which you, or someone other than the health plan on your behalf, has paid in full.

Confidential Communications: You have the right that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or locations, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (email), you are entitled to receive this notice in written form. Please contact us by using the information listed at the end of this notice to obtain this notice in written form.

HOW TO CONTACT US:

Sava Podiatry and Wellness Centers
1675 Cumberland Pkwy SE Ste 201
Email: savapodiatry@gmail.com

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us by using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us by using the contact information below. You also may submit a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Human Services upon request.

We support your right to protect the privacy of you protected health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Human Services.

I have received a paper copy of the confidentiality policy, as required by HIPAA of 1996.

Signature of Patient/Guardian: X_____ Date: _____

Name of Contact Person_____

Telephone:_____ Fax:_____

Email:_____

Address:_____

SAVA PODIATRY AND WELLNESS CENTERS

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INSTRUCTIONS FOR CLAIM CHECKS SENT TO PATIENT

I, _____realize that I may receive checks from my insurance carrier for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages, to the above office immediately. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

If you receive a claims check, denial, explanation of benefits or other documentation from your health plan, you agree to immediately send that check/documentation to us directly. If you receive a claims check, please do the following:

1. Endorse the check;
2. Under your endorsement, write, "Payable to the order of Sava Podiatry and Wellness Centers".
3. Under this write, "For Deposit Only";
4. SEND THE CHECK and ALL CORRESPONDENCE AND DOCUMENTATION to us at:

   Sava Podiatry and Wellness Centers, 1675 Cumberland Pkwy SE, Ste 201, Smyrna, GA 30080

You can also send correspondence to us via email to savapodiatry@gmail.com.

I agree to return claims checks, denials, explanation of benefits or other documentation received from my health plan to Sava Podiatry and Wellness Centers to the above address immediately upon receipt. I agree to send all correspondence received to Sava Podiatry and Wellness Centers via email. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for services from Sava Podiatry and Wellness Centers are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance or health plan, including co-payments, co-insurance and deductibles.

Patient Name (Print) _____ Date_____

Guardian or Patient Signature: _____

I, _____realize that I may receive checks from my insurance carrier for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages, to the above office within 7 days. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

Patient or Guardian Signature _____Date _____

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FINANCIAL AGREEMENT

We want you to receive the best care possible and be totally satisfies with our service. Our experienced office staff will be happy to answer any questions regarding your account. Here are some important
points to remember regarding your care in our office.

1. To keep medical care and billing costs down, payment for services is due at the time services are rendered unless payment arrangements have been approved in advanced IN WRITING by our office manager.
2. We are contract providers for Medicare and many private insurance plans. In those cases, we have agreed to accept their determination of fees for covered services, these payments are due at time of service. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.
3. Not all services are a "COVERED" BENEFIT IN ALL INSURANCE POLICIES. Your policy is a contract between you and your insurance company, and NOT between Sava Podiatry and Wellness Centers your insurance company. When we check eligibility and benefits this does not guarantee payment, this only ensures that it is an active plan. If your insurance requires prior authorization or referrals for supplies dispensed or services rendered, please understand that it is your responsibility. Your insurance does not release details regarding any pre-existing conditions, exclusions, hidden clauses, and non-covered services. Medicare and some insurance companies select certain services that they will NOT cover. Payment for these services is the responsibility if you, the patient. We strongly encourage you to carefully read your insurance policy so that you will know the conditions and circumstances of your coverage.
4. Insurance companies may impose a waiting period before providing coverage and they may exclude coverage for what they determine to be "pre-existing conditions." They may also require that you obtain prior approval before treatment.
5. Our fees are generally considered to fall within acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 70% or 80%) of usual, customary, and reasonable (UCR) for this region.
6. When we can verify your coverage and benefits in advance for your insurance, we will accept assignment of your insurance, we will bill the carrier directly. Accepting assignment means that your insurance company will send us the bulk of the payment for treatment and that you, the patient, pay us directly for the deductibles, copayments and non-covered services and fees. In these circumstances, payment of your portion will be estimated at the time of services and must be paid at that time. When the insurance company does pay us, or at 30 days from the date of billing your insurance company, whichever occurs first (insurance companies are required by law to pay or deny claims, within 30 days), you will be responsible for any remaining balance, or we will refund you any overpayment you have made. Our accepting assignment of your insurance benefits does not relieve you of your personal responsibility for prompt payment of the total bill. If your insurance company does not completely or promptly pay, you are responsible for paying the remaining balance immediately upon receipt of a bill. As a patient of this office, to expedite proper payment, we will complain to the Insurance Commissioner and/or Department of Corporations on your behalf regarding payment of claims.
7. Any account balance not paid in full within 60 days will be subject to a monthly finance charge of 3% per month (36% A.P.R) and a monthly cost of rebilling/account maintenance charge of $5. These rates and charges are subject to change upon 30 days written notice. If any account balance should remain unpaid for 90 days and the Doctor refers the account to a collection agency or attorney, the responsible party will be charged a 30% collection fee and the costs of collection, and these fees costs will be added to the account balance.
8. Payments will not be delayed or withheld, regardless of any lawsuit's liens, insurance coverage the pendency of claims thereon or the outcome of medical treatment. All proceeds from the plan are assigned to the Doctor where applicable.
9. Requests for non-customary assistance such as special billing, rebilling, completion of forms and special reports and information requests are not included in our fees and will be billed separately. X-rays and charts are part of your permanent medical records in our office. Copies can be provided upon advance notice and payment of supplicating costs.
10. If your diagnosis or treatment involves others, such as hospitals or laboratories, you will be billed by these entities separately.
11. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
12. CHECK Policies: If a check is returned for insufficient funds and/or closed account, you will be charged a $25 return check fee in addition to your balance owed. You will have 7 business days to make good on your check, otherwise, action will be taken.

Patient or Guardian Signature _____Date _____

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Your insurance coverage is a contract between you and your insurance company. Please present your insurance card each time you visit to ensure we have the proper filing information to submit claims. Otherwise your visit may not be covered, and you will be responsible for payment.

If we are **out-of-network** with your insurance company, you must file for reimbursement directly with your insurance company. It is your responsibility to find out the process, and to verify if we are in network with your insurance. What this means for you is that we invite you to utilize your health insurance in a different way by taking advantage of your out-of-network benefits. Most people don't know about or make use of these benefits.

Our fees for services range from $135-$1000 depending on the provider and the service being provided. Those fees are due the day of service and we can provide you with the appropriate documentation to submit to your insurance company so that you can potentially receive reimbursement.

Payment is due at the time of service. For your convenience, we accept cash, check or credit card; however, if you are a new patient only cash or credit is accepted on your first visit. Copays and deposits towards deductibles are collected before the appointment. We verify your insurance before every visit, however verification of benefits is NOT a guarantee of payment. You may have a deductible in your insurance policy.

A deductible is the amount that your insurance company requires you to pay out of pocket for medical expenses before the insurance company will pay for medical expenses. The deductible amount is not decided by Sava Podiatry And Wellness Centers, it is determined by your contract with your insurance company. The following is the policy of Sava Podiatry and Wellness Centers regarding deductibles. The same values apply for self-pay patients:

- If you are a new patient or have not been seen in our office in the past 3 months, and you have a deductible that exceeds $200, you will be responsible for paying a $200 deposit before you see the doctor.
- If you are a current patient, seen in the office within the last 3 months, you will be responsible to paying a $75 deposit before you see the doctor.
- If your visit exceeds the $200 deposit paid for new patients, or $75 for existing patients, you will be responsible for the remaining balance upon checking out after you see the doctor. The remaining balance will be an estimate of the allowed charges for the day. This estimate is based on our current contract with your insurance company and the fee schedule they have provided us. It is not guaranteed by the insurance company to be 100% accurate. If there is a balance or credit on your account, you will be informed.
- This policy will apply until your deductible has been met.
- If your insurance automatically pays your deductible from your HSA account, you will be refunded the credit balance on your account after your insurance has processed the claim for the visit, and you have no other balance due on your account.

Patient Signature_____ Date_____

PATIENT ACKNOWLEDGEMENT

I,_____(print Patient's name or Guardian), hereby acknowledge that at the beginning of my treatment or services rendered by the Practice, I have been furnished with the Practice's Financial Agreement. I voluntarily sign this acknowledgement that I consent and agree to the Conditions of the Practice.

Patient or Guardian Signature: _____ Date: _____

Printed Name: _____

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We would like to bring to your attention that health care benefits today have become extremely complicated. Health benefit packages vary greatly based on company and individual selection. For this reason, as well as the ever-changing federal healthcare law, our offices have found it necessary to adopt the following policies below.

I, _____(Patient) understand that I am responsible for payment of my deductibles, copayments or coinsurance. Sava Podiatry and Wellness Centers (hereinafter, the "Practice") will not in whole or in part waive deductibles, copayments or coinsurance unless the patient meets specific hardship requirements. It is the policy of the Practice to collect these amounts and all Patient Responsibility owed to the Practice. The Patient also acknowledges that Practice is out of network, which means that the Physician does not have a managed care contract with your health plan. If claims are submitted out-of-network by the Practice, the Patient will be responsible for balances remaining after all health plan and patient payments are received by the Practice. This is commonly referred to as a balanced bill.

THE ESTIMATED RATE AMOUNT FOR OUT OF NETWORK SERVICES IS AVAILABLE UPON YOUR REQUEST. Please note that such estimates cannot account for unforeseen medical circumstances that may arise while the services are performed. If you have any questions regarding the participating status of your Physician or Practice with your insurance carrier, please do not hesitate to ask our staff or refer to our website. Submission of a claim to your insurance carrier is as a courtesy only. The Patient is responsible for their coinsurance, copayment, deductible, balance bill (if out-of-network) and any non-covered services within 30 days of written request by the Practice. If Patient fails to pay within 30 days of written request by the Practice, Patient will be responsible for interest at a rate of 3% per month. The Patient is also responsible for obtaining any required pre-authorizations or referrals required by your insurance carrier.

¬ If you have an HMO, you must verbally inform our front desk prior to treatment. I understand that Sava Podiatry and Wellness Centers does not participate in HMOs and that I may be responsible for full payment.
¬ Please realize our office does not know and cannot determine your individual healthcare benefits. We will do our best to maximize coverage for your visit within accepted rules and regulations. However, knowing your benefits and financial liability is ultimately your responsibility.
¬ Ensuring that our doctors are participating in your health plan is your responsibility. Our office will try to ensure that we accept your health plan prior to your visit, however due to increased plan options, our office cannot guarantee that we are participating in your plan. If we are unable to get reimbursement through your plan you will be responsible for all service charges.
¬ Please inform our office of any insurance, address, email, or telephone number changes.
¬ Our office performs what we feel is medically necessary for your health care based on established medical guidelines and discussion with you.
¬ Our office will prescribe and recommend those medications which we feel are best for your health. We will do our best to work within any known restrictions. However, please realize any problems concerning the cost or coverage of your medication is between you and your prescription plan. These are financial issues not medical (i.e., prior authorizations).
¬ Not all services are covered benefits with all insurance plans. Any treatment, including the writing of prescriptions, is not covered under preventative care. Service not covered by your insurance plans are expected to be paid at time of service.
¬ You should always be aware of the services being performed and discuss them with the provider.
¬ You are responsible for applicable charges as per your insurance agreement (such as deductibles, percentage, after hour fees, co-pays etc.) or any performed services not covered by your insurance policy.
¬ If you are turned over to a collections agency or write a bad check, you will be responsible for any costs incurred in collecting the balance.
¬ Be aware that payment is expected at the time of service and that our office accepts CASH, VISA, MASTERCARD and DISCOVER.
¬ If you have an outstanding balance from a previous visit, you will be asked for payment at your next visit.
¬ There may be a fee for the completion of paperwork (disability forms, FMLA, prior authorizations, etc.)

As your physician our relationship is with you and **not** your insurance company. We realize that problems may arise, and we will do our best to work with you through these situations. Please do not hesitate to ask us if you have any questions as we are here to help you. I have read and understood the above policy ad I agree to meet all my obligations.

Patient Signature_____ Date_____

UNENCRYPTED EMAIL AND TEXT POLICY

I, _____, (patient/guardian) hereby voluntarily provide my email and cell telephone number to Sava Podiatry and Wellness Centers (hereinafter, "Practice").

I agree to permit PRACTICE and their Authorized to communicate with me by UNENCRYPTED email and text message with respect to the medical claims submitted to my health plan and with respect to any balances due to PRACTICE after health plan and other payments received by PRACTICE and for balances not covered by my health plan, coinsurance, deductibles or any other balance deemed client responsibility as well as appointment reminders. To be clear, I am consenting to communication by UNENCRYPTED email as required by 15 USC 7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such a case, I will notify PRACTICE in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to UNENCRYPTED email communication in writing to PRACTICE. There are no hardware or software requirements needed to receive UNENCRYPTED email communication from the treatment center or their authorized representatives other than an active UNENCRYPTED email account obtained from a vendor that provides such email accounts.

PRACTICE and their Authorized Representatives will not sell, share, or rent your email address or any other personal information collected on this consent.

Signature: _____ Date:_____

RELEASE AND ASSIGNMENT

1. For good and valuable consideration, the receipt of which I hereby acknowledge, I irrevocably authorize you and your representatives, licenses and assigns (hereinafter "you") to film, videotape, photograph and/or record me in connection with Kinna Patel, Sava Podiatry and Wellness Centers, and all associated staff members, and to use such film, videotape, photography and /or recording any number of times in any manner or medium now or hereafter known including without limitation, for example, home video devices, audio records, broadcast television, cable, pay- per- view, Pay TV, theatrical motion pictures, etc… and in advertising and promotion of such uses and for purposes of trade. You shall not be obligated to use any such film, videotape, photography and/or recording.

2. I hereby release and assign to you all rights, worldwide an in perpetuity, relating to such film, videotape, photography, and/or recording and their uses, including but not limited to, the sole and exclusive right to reproduce, distribute, broadcast, sell and otherwise exploit same by any means now or hereinafter known or developed, in whole or part, with the right to edit or modify and to secure copyrights in connection with the aforesaid uses, as your sole property. In addition, you may use my name and likeness in connection with the sale and advertising of the foregoing.

Print Name: _____ Signature: _____
Date: _____ Decline:_____

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

The law may prohibit the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person. During the course of your care at Sava Podiatry and Wellness Centers, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis WILL NOT involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state, and federal requirements. It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing, or other objects. These objects may then be transferred to a third party for cleaning or disposal. By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Sava Podiatry and Wellness Centers to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Signature: _____ Print name:_____
Date:_____

As of June 1, 2023, there will be a $50 charge for appointments cancelled less than 24 hours before a scheduled appointment time, as well as for no show appointments and for appointments rescheduled more than three times regardless of notice given.

Unlike other offices, we pride ourselves in providing quality care for our patients and block off significant time when we schedule your appointment. This is so our providers don't feel rushed when they see their patients. We respect our patients time, and we expect them to respect ours as well.

If there is an insurance issue, you are responsible for knowing what your insurance covers. We are clear when we schedule appointments that we will collect upfront if there is an unmet deductible or if we are out of network with your insurance.

Due to the overwhelmingly long time it takes us to verify insurance coverage and find out eligibility/benefits on each patient, we do not have time to provide this information in advance or explain coverage to each patient on how their insurance works. We unfortunately have nothing to do with the plan that you choose to select when purchasing insurance coverage.

Furthermore, we are a specialist's office, so coverage may be different for us in comparison to your primary care physician. It is the responsibility of the patient to know this information regarding their own insurance company that they elected to purchase.

I understand this information and agree to these terms.

_____ _____

Patient Signature Date