ALLAN I. Rosenthal DPM, FACFAS
30 Prospect Street
Ridgefield, CT 06877
(203) 431-0048

Financial Policy

We will request a copy of your insurance card
You must notify us of any changes in your address, phone number, and insurance information.

COPAYMENTS- We are required to collect your copay at the time of service. Please be prepared to pay at each visit.

ADMINISTRATIVE CHARGE- Patients will be billed a $10.00 billing charge if applicable payment (including copay) is not made at the time of service.

FINANCE CHARGE- A monthly finance charge of 1.25% which is an annual percentage rate of 15% will be added to any unpaid balances after 90 days.

REFERRALS- If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral you will be required to sign a financial waiver making you responsible for your bill or your appointment will have to be rescheduled. **SELF PAY AND NON PARTICIPATINE PLANS**- Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier who will reimburse you directly.

MEDICARE- We will submit to medicare for the Medicare allowed amount. The patient will be responsible for the deductable and the 20% co-insurance, which the patient can bill the secondary insurance if you have one.

PRIVACY NOTICE- It is our intent in this office to treat you professionally and provide the best foot care possible. During the course of your treatment it may be necessary for us to share information (both medical and personal) about you with other professionals within and outside of our office. In some instances information may be sent out of this office for transcription purposes. We will share this data only when necessary and will keep it in strict confidence to protect you identity.

We accept CASH, CHECK, MASTERCARD, AND VISA!

Thank you for taking time to review our policies. Please feel free to ask any questions or share with us any concerns.

RESPONSIBLE PARTY
SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICE

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature