DR. ADAM KLEIN FOOT CARE

HIPAA & Financial Responsibility

PATIENT INFORMATION			
LAST NAME	FIRST NAME		M.I.
SSN	DATE OF BIRTH	SEX	MRN
STREET ADDRESS			
STREET ADDRESS CONTD.			
CITY	STATE	ZIP CODE	
HOME PHONE	CELL PHONE	EMPLOYER NAME	

HIPAA & Financial Responsibility

I certify the information that I have provided is correct. I hereby give permission to Dr. Adam Klein, DPM, PC to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, AMEX, cash or check. I have received, or reviewed a copy of the HIPAA form. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co pay/co insurance/deductible. I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt equal to up to 45% of the balance due and 16% annually.

I consent to receive calls from Dr. Adam Klein, DPM, PC, collection agency/attorney representative(s) should my account be placed for collection at the phone number(s), including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system." If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify

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benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied. This notice is effective April, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice o Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you ma request a written copy of a revised Notice of Privacy Practices from this office.

There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

For more information about HIPAA:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington D.C. 20201

(202) 619-0257

Toll Free: 1-877-696-6775

Patient / Agent / Guardian Signature 07/01/2025