INSURANCE AND PAYMENT AGREEMENT

1. Please keep in mind that it is your responsibility to obtain a referral (if needed) from your primary care physician and to make sure that it is current. If a referral is needed and not obtained, payment for services will be denied by your insurance company and will become your responsibility.

2. **Medicare Patients:** In order for Medicare to cover routine care services rendered in this office you must have seen your primary care physician within the last six (6) months. Please have that date with you when you come for your appointment. If a current date is not available, payment for service(s) is your responsibility.

3. It is your responsibility to use the doctors, hospitals, and labs that are covered by your insurance. It is also your responsibility to check with your insurance to see if services and procedures are a covered item. Insurance companies often have many different policies under the same company name; it is impossible for us to know all the limits of each plan. If the services you receive are not a covered benefit, it is your responsibility to pay for these non-covered services.

4. No matter what the circumstances, the person who signs the financial responsibility portion of the "New Patient Information" sheet is the liable party for the incurred expenses of services performed. We cannot bill persons that are court assigned to pay medical expenses; the person signing for the services must pay them. It is your responsibility to receive reimbursement from the liable court assigned person.

5. If you have a "co-pay", it is due at the time of service. If you pay a percentage of each office visit and/or services, we will bill you or refund you the difference if an over payment develops after we receive an explanation of benefits (EOB) from your insurance company.

6. If you receive payment for services provided by this office from your insurance company and you have not already paid for these services in advance, it is your responsibility to bring that payment to this office to pay for the services you received and for which the insurance company paid to you. Any checks received by this office from you or your insurance company for services rendered through this office will be credited to your account.

7. You agree, in order for us to service our account or to collect any amounts you may owe, we 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 automatic dialing device, as applicable.

8. It may be necessary for us to submit your medical information to other individuals and entities in addition to Dr. Don Tupper, Podiatrist and the employees of Coshocton Foot Health Center for insurance and reimbursement purposes, for consultation or for audit and legal reviews and/or to billing companies (including companies that facilitate patient information transmitted electronically). By signing below, you authorize Dr. Don Tupper, Podiatrist to release your medical information to third parties when necessary.

9. We are not responsible for any charges incurred as a result of not following the rules set forth by your insurance company regarding services you receive. Any account with an outstanding balance that is the patient's responsibility and is over 90 days old runs the risk of being turned over to our collection agency.

10. Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Tupper will review your health\history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Your signature below indicates that you understand, accept and agree with fully and completely, the provisions and disclosures in this insurance and payment agreement and agree that the Lender/Creditor may contact me/us as described above.

Signature:_____ Relationship to Patient:_____

Date: _____