



# THE FOOT WELLNESS CENTER

Dr. Judith E. Rubin, D.P.M., P.A.  
21216 Northwest Freeway Suite 240  
Cypress, Texas 77429  
281-955-5500  
281-890-9365 Fax

## SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Patient Name \_\_\_\_\_

Medicare or Social Security Number \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

### EFFECTIVE JULY 1, 2002

**Effective July 1, 2002, Dr. Rubin will be implementing a cancellation / no show policy.**

**Any no-show or cancellation without a 24 hour notification for an appointment with Dr. Rubin or Dr. Hancock will be subject to a \$50.00 non-notification fee, payable before the next scheduled visit. This will be strictly enforced.**

\_\_\_\_\_  
**Judith E. Rubin, D.P.M.,P.C.**

**I agree and will adhere to the above policy.**

\_\_\_\_\_  
**Your signature**

# THE FOOT WELLNESS CENTER

Dr. Judith E. Rubin, D.P.M. P.C.

## Welcome to the Foot Wellness Center!

Our practice has contracts with many HMO's, PPO's, IPA's, Medicare and Medicaid. It is the **patient's responsibility** to obtain a referral from their primary care physician before making an appointment with our office.

## Financial Agreement

All accounts, including those filed with insurance companies must be paid in full within 90 days. Any balance on an account after that time is subject to collection activity. We accept checks with proper identification. We also accept cash, debit and credit cards and money orders.

## Medicare

The Foot Wellness Center will accept assignment from Medicare for covered expenses. Any expenses not covered by Medicare will be the **patient's responsibility** to pay.

## Contracted Insurance

The **patient is responsible** for any **deductible** and **co-pays** at the time of service. It is also the patient's responsibility to pay any and all charges not covered by the patient's insurance plan.

## Self Pay Patients

Self pay patients are responsible for all charges at the time of service, **there are no exceptions**. If you are unsure of what your insurance pays, please ask.

## DURABLE MEDICAL GOODS

It has been our experience that most insurance companies do not pay for *durable medical goods*, that is items such as Orthotics, cast covers, surgical shoes, fungoid tincture, formalin solution, tapes, etc.

THE FOOT WELLNESS CENTER CANNOT FILE THE ABOVE ITEMS WITH YOUR INSURANCE COMPANY.

We advise all patients who receive *durable medical goods* at the time of treatment, to obtain a copy of your receipt, so that you may file a claim with your insurance company for reimbursement.

PAYMENT IN FULL WILL BE EXPECTED IN THE EVENT THAT YOU RECEIVE ***DURABLE MEDICAL GOODS*** AT THE TIME OF TREATMENT.

WE CANNOT ACCEPT ASSIGNMENT AT ANY TIME FOR THESE ITEMS.

Patient Name (Printed) \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

In the event that we need to get medical goods, such as; cold machines for surgery patients, wheel chairs, walkers, custom shoes, etc., we need your signed permission to fax your personal information to the appropriate source.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS**

I, the undersigned, hereby permit my insurance company to send all insurance benefits earned by Dr. Rubin for services rendered to The Foot Wellness Center. Filing your claims is a free service provided by The Foot Wellness Center. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize The Foot Wellness Center to release all information necessary to secure the payment of benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Co-Pays and/or deductibles will be collected at the time of service)

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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 chose and understood the notice.

Please sign and date below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date