Lighthouse
FOOT & ANKLE CENTER, PC

Office Policy

1. We will file insurance claims for you with benefits assigned to Lighthouse Foot And Ankle Center.
2. **Mainecare Insurance is no longer accepted by this practice**.(If the patient chooses to stay with the practice, they will be responsible for any balances billable to Mainecare).
3. Payment of co-payment, co-insurance, and deductible is expected at the time of your visit.
4. Patient is responsible for obtaining referrals and pre-authorizations from their insurance carrier and primary care physician.
5. Lighthouse Foot And Ankle Ctr has **a credit card on file policy** for insurance co-pay's, deductibles, patient balances, and/or future services. Please provide your credit card at check-in or check-out to have the information saved to your account.
6. I hereby give permission to have my feet and ankles examined and treated by Dr. Kurlanski.
7. If patient does not have health insurance, payment in full is expected at the time of your visit unless previous arrangements have been made.
8. A notice of our Privacy Act will be issued by request.
9. Cancellations should be made 24 hours prior to the patients appointment.

I authorize this form to act as acknowledgement that I have been offered a copy of Dr. Kurlanski's Notice of Privacy practices. I authorize the release of medical information to my primary care physician/referring physician and any other health care providers that are treating me. I authorize this form to act as the release of medical information to anyone which I direct. Information will only be released by written notification. We reserve the right to charge $5.00 for the first page and .45 cents per page for any records copied, after the initial copy was given.

I understand that a 5-business day notice must be given in order to have my file copied and released to myself or another doctor. This will allow us to ensure that all of the requested information, including x-rays are incorporated.

I understand and agree that regardless of my insurance coverage and/or status I am responsible for the balance on my account for any professional services rendered. I will notify the doctor of any changes in my health status or any of the above information, which is true to the best of my knowledge. I authorize use of this form on all insurance submissions. This form may be used as a release of information. I authorize my doctor to act as my agent in helping me obtain payment from my insurance company and authorize payment directly to my doctor. A copy of this form is as valid as the original. I authorize the release of medical information to my insurance carrier in order to process any claims for services rendered and I authorize payment of medical benefits directly to "Lighthouse Foot And Ankle Center PC"

Signed:_____ Date:_____