DR. IVAN J. NOSACEK, P.A.

3006 Mitchellville Road
Bowie, Maryland 20716
Tel: (301) 390-3338

Welcome to Our Practice

Thank you for selecting us for your foot care needs. We hope you will find our office convenient and the staff courteous. Hours of operation are as follows, we are closed on nationally-recognized holidays.

Monday – 8 am until 4 pm
Tuesday – 2 pm until 6 pm
Wednesday – 8 am until 4 pm
Thursday – 2 pm until 6 pm
Friday – 8 am until 12 noon

Our office participates with the following health insurance plans.

- CareFirst Blue Cross Blue Shield PPO (Federal, Non-Federal, and affiliated network plans)
- CareFirst Blue Choice HMO
- CareFirst Blue Cross Blue Shield of Maryland PPO
- Medicare
- AETNA
- CIGNA
- United Healthcare

Financial Policy: Payment in full is required at the time services are rendered, unless you are currently enrolled and eligible under one of the above insurance plans. Please understand health plans have different copays, deductibles, and rules regarding allowed visits for certain covered services, which may or may not be defined by your individual policy and/or employer group. If our office is participating with your health plan, we will honor their fee schedule and discounts, and you will be responsible for your co-payments and/or deductible (both may apply). If our office is not participating with your health plan, payment in full is due for all services at the time you exit our office. We do not honor non-participating plan discounts. We accept the following methods of payment: cash, check, money order, MasterCard, VISA, and American Express. There will be a $25.00 processing fee for all returned checks.

Patient Statements: When a claim is submitted to one of the above insurance plans on your behalf, we notify them of any payment made by you on the day of your visit. Once they consider your claim, and if you still owe a balance after their decision, a statement will be sent to you. You have 30 days to pay your balance in full.

Referral Forms for HMO Plans: If your insurance plan requires a *written referral* for your visit, *you must bring it with you at the time of your appointment.* It is the responsibility of the patient to be prepared for their visit at the time they are seen. If you do not have a referral at your appointment time, you may reschedule your appointment, or sign a waiver of benefits for that visit and make payment in full that day. We do not encourage patients to give up their insurance benefits. We request that you follow your health plan rules so you can receive the most optimal benefit your health plan provides. Waiving benefits may affect consideration of future services.

Special Forms: We will complete special forms such as disability statements, extended leave forms, etc. for a fee. These forms require provider time to complete and make medical statements that affect your care. The fee for completion varies and starts at $15.00 per document, with one courtesy copy provided to you. The fee is to be paid at the time of completion. To maintain privacy, we do not mail special forms, but require the patient to pick them up personally.

Missed Appointments: As a courtesy to you, the office staff confirms appointments 24-48 hours in advance. If you are unable to keep your appointment, a 24 hour notice is required. If you provide less than a 24 hour notice, or you do not appear for your appointment, a 'missed appointment' fee will be charged to your account in the amount of $25.00. This amount must be paid prior to any future visits with our office.

I understand the above administrative and financial rules of Dr. Ivan J. Nosacek, P.A.

Patient's Signature: _____ Today's Date: _____

Print Your Name _____ Intake Initials: _____

Revised May 2009

RELEASE OF MEDICAL INFORMATION
ASSIGNMENT OF BENEFITS
PAYMENT AGREEMENT

I authorize **Dr. Ivan J. Nosacek, P.A.** to release medical information to my insurance carrier for the processing of medical claims. I also authorize and request that any benefits extended by the submission of medical claims to my insurance plan be paid directly to **Dr. Ivan J. Nosacek, P.A.** It is understood with my signature below, this authorization is valid for all medical services provided by **Dr. Ivan J. Nosacek, P.A.** until revoked in writing by myself or my authorized agent.

Copayments: If your health plan assigns a copayment, it is due at the time of service. Copayment amounts are defined by your health plan and are applicable only to plans we are participating with at the time of your visit. If the amount is not identified on your insurance card, it is your responsibility to know the amount due at the time you are seen.

Deductibles: Deductibles are defined by your health plan. In some cases, the amount can be defined at the time of service. Please note that deductible amounts are inherent on claims submissions by other providers. A deductible amount may only be a prediction of the true amount owed for services rendered.

Coinsurance: Coinsurance is calculated after your primary insurance has considered and/or paid your claim. The amount defined by the primary and secondary insurance plans is *per their processing guidelines* and may or may not be accurate if it is a plan our office is not participating with at the time of your visit.

Referrals: It is the *patient's responsibility* to know if their health plan requires a referral for services. Referrals are accepted for participating plans only. Additionally, the referral must be made available *prior* to any services being provided to you. It is also your responsibility to make certain your referral covers your visit. We do not contact primary care physicians for referral documents. If you appear for an appointment without your referral, you will be asked to sign a waiver of benefits – pay for the service in full – and a claim will not be submitted.

Non-covered Services: Each patient's insurance coverage is different and some services may not be covered. We do attempt to inform the patient prior to a potentially non-covered service, if historically it has been shown there may be no coverage. For these services, payment in full at the time you are seen is required. We will submit a claim for consideration, and if payment is made by the health plan, you will be promptly refunded.

Patient Statements: If it has been agreed upon that a statement will be sent to you after services are rendered, payment is due upon receipt. Failure to do so could lead your account to be transferred to a collection agency. All collection fees, legal fees, and interest rates will be paid by the patient, and not our office. If you are having difficulty with payment – *please contact us immediately*.

MEDICARE PATIENTS WHO HAVE SELECTED A "MEDICARE ADVANTAGE PLAN":

> If you have been approached by a health insurance plan that provides you with benefits supposedly more extensive than the standard Medicare coverage – *PLEASE NOTE* – you are obligated to follow your new insurance plan's rules and regulations for access to medical care. Our practice may or may not be participating with your new insurance plan. It is your responsibility to inform us PRIOR TO SERVICES that you have made a health plan change. Your traditional Medicare card will no longer be accepted as a form of payment for your medical services. If it is found you have made a change in health insurance coverage and did not provide us with the correct information PRIOR to services, you will be responsible for the full amount of all fees for all services provided to you.

MISSED APPOINTMENTS: Our office charges **$25.00** for missed appointments. It is the responsibility of the patient to manage their own calendar for follow-up appointments. As a courtesy to our patients, attempts will be made to confirm appointments in advance.

My preferred contact telephone number is: (_____) _____ - _____ **Home** **Work** **Cell**

With my signature below, I have read and understand the above policies in regards to healthcare services provided by Dr. **Ivan J. Nosacek, P.A.** I have also had the opportunity to ask questions and have them answered.

Patient/Representative's Signature _____ Today's Date: _____

Printed Patient Name: _____ Intake Initials: _____