



CORNERSTONE FOOT & ANKLE

Sewell
100 Kings Way E, Suite D6
Sewell, NJ 08080

Mount Holly
516 High Street
Mt.Holly, NJ 08060

Glassboro
707 N Main Street, Suite 3
Glassboro, NJ 08028

Marlton
525 Route 73 S
Evesham Commons Suite 304
Marlton, NJ 08053

Cherry Hill
457 Haddonfield Road, Suite 110
Cherry Hill, NJ 08002

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Name: _____ **Nickname:** _____

Sex: M / F **SS#:** _____ **DOB:** _____

E-mail: _____ **Home #:** _____

Address: _____ **Work #:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell #:** _____

Primary Care Physician: _____ **PCP Phone:** _____

PCP Address: _____

Primary language: English Spanish **Race (optional):** White Black/African American Hispanic/Latino
 Other: _____ Asian American Indian/Alaska native Native Hawaiian/Pacific Islander

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Relationship to Patient: _____ **Preferred Pharmacy:** _____

Marital Status: single married widowed divorced **Spouse/Partner name:** _____

Employer/School: _____

Primary Insurance: _____ **Policy Holder's Name:** _____

Identification Number: _____ **Date of Birth:** _____

Secondary Insurance: _____ **Does your insurance**

Identification Number: _____ **require a referral?** yes no

Current medications prescribed by a doctor or over-the-counter: _____

Shoe size _____ **Height** _____ **Weight** _____

What type of shoes do you wear most often? _____

What shoes (if any) do you wear at home? _____

What is the reason for your visit today? _____

How long has this bothered you? Days / Weeks / Months / Longer

What treatments have you tried & have they been efficient? _____

HOW DID YOU HEAR ABOUT US?

Physician(Dr.?) Health Fair/Event (which one?) Google

_____ Our website

Family/Friend Other Website (which one?) Kennedy Hospital

_____ Facebook

Other Yelp



We at Cornerstone Foot and Ankle are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding on our payment policy.

Unless INSURANCE ARRANGEMENTS have been approved in advance by our staff, payment for services is due at the time services are rendered. We accept payment in the form of cash, check, MasterCard, American Express, Discover, or Visa. We will be happy to help you process your insurance claim at each visit.

Returned checks and balances older than 30 days are subject to additional collection fees and interest of 1.5% per month. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Insurance is a contract between you and your insurance company.
2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R.. "U.C.R." is defined as Usual, Customary and Reasonable fees for this region. Thus, our fees are considered Usual, Customary, and Reasonable by most companies. This does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard of fees and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.
4. **MEDICARE PATIENTS:** We would like you to understand that accepting assignment means that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% (co-insurance) of what Medicare allows. You are also responsible for services that your supplemental/ secondary insurance does not cover. If your supplemental/ secondary insurance does not pay this amount, YOU are responsible for it.

The filing of insurance claims is a courtesy that we have always extended to our patients. However, all charges are your responsibility, not your Insurance Company's. We will make our best effort to collect from them, but if, despite our best efforts, we are not successful, you are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

1. **INSURANCE:** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **PATIENT BILLING:** All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. Postdated checks are not accepted. Co-insurance and unmet deductibles are due prior to scheduled surgeries and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. **SELF PAY:** Payment in full is due at the time of service if you do not have health insurance. You are ultimately responsible for payment of charges for services you receive from our office.

4. **CREDIT / DEBIT CARD ON FILE:** We require a credit or debit card on file with our office if we will be billing insurance for you. You will be asked for a credit card at the time you check in and the information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card and a copy of the receipt will be sent to you. We only have to swipe your card once per year. You can cancel the contract at any time in writing.

5. **REFERRALS/AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician **prior** to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. You will also be given the option to reschedule your appointment.

6. **CANCELLED/MISSED APPOINTMENT FEE:** If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There may be a \$35 fee for any appointment canceled or rescheduled within 24 hours of the scheduled time. Additionally, there may be a \$35 fee if you miss a scheduled appointment. If you miss 3 or more appointments, you may be required to pay a \$50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.

7. Payment is due for rendered services 30 days from the date of your billing statement. Unpaid previous balances must be paid in full prior to any additional visits, unless arrangements have been made with our financial counselor. An additional \$35.00 will be added to your statement if the check is returned from your bank.

8. **COLLECTIONS FEE:** You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. There will be a \$10 re-billing fee acquired on your third notice. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a 35% fee will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

9. **PHYSICIAN PHONE CALLS:** Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

10. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the state of New Jersey. Fees must be received prior to record delivery. No more than 5 pages may be faxed.

11. **ADMINISTRATIVE SERVICES:** There is a \$25.00 charge for each Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorization for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

12. **NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS:** If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

13. **PATIENT REFUNDS** - Please allow 60 days from the time your insurance company responds to a claim for your deposit refund to be processed. Refunds will be issued in the form of a paper check that will be mailed to your home address.

I, _____, have received, read, and understand the financial policy at Cornerstone

Foot and Ankle.

Signature of Patient/Guardian

Date