WILLIAM J. NAMEN II D.P.M., P.A.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any information acquired in the course of my treatment to my insurance company. I request a payment of authorized benefits be made to WILLIAM J NAMEN II, DPM. PA for benefits on my behalf for covered services rendered.

{MEDICARE PATIENTS} I authorize any holder of medical or other information about me to be released to the Healthcare Financing Administration and its agents any information needed to determine these benefits for related services.

- **I certify the information I provided with regard to my insurance is correct.**
- **I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.**
- **If this account is assigned to an attorney for collection and or suit, the prevailing party should be entitled to reasonable attorney's fees and cost for collection and any collection company.**
- **I authorize medical treatment by WILLIAM J NAMEN II DPM, PA to perform the necessary medical evaluation and procedures including but not limited to physical examination, diagnostic examination, diagnostic blood work, x-rays, minor surgery, major surgery, and treatment modalities.**

NOTICE OF PRIVACY PRACTICE

I acknowledge receiving a copy of the Notice of Privacy Practice and agree with the disclosure of information as stated.

Patient Name _____

Parent or Legal Guardian of Child _____

Signature _____

Date _____

WILLIAM J. NAMEN II D.P.M., P.A.

LIFETIME AUTHORIZATION

REALEASE OF INFORMATION: I the below named patient, do hereby authorize my physician examining and or treating me to release any third party payor {such as insurance company or government agency ex. BCBS of Florida or MEDICARE} any medical, psychiatric condition, alcohol or drug related conditions. AIDS/HIV and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment of such treatment and or diagnosis.

PHYSICIAN INSURANCE ASSESMENT: I the below named subscriber, hereby authorize payment directly to WILLIAM J, NAMEN II DPM., PA. Medical and surgical benefits herein specified and otherwise payable to me for their services and described but not to exceed the reasonable and customary charge for these services.

MEDICARE AND MEDICAID: Patient's certifications authorization to release information and payment request. I certify that the information given by me in applying for payment under the Tittle XVIII/XIX of the Social Security Act is correct. I authorize any holes of medical or other information about me to release to the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this of a related Medical /Medicaid claim. I hereby certify all insurance pertaining treatment shall be assignment to the physician treating me.

I permit a copy of this authorization and assignment to be used in place of the original which is on file at the physician's office. This assignment shall remain in effect until revoked by me in writing.

Patient Name _____

Parent or Legal Guardian of Child _____

Signature _____

Date _____

WILLIAM J. NAMEN II D.P.M, P.A

FINANCIAL POLICY

It is the policy of Dr. William J. Namen II D.P.M., P.A to provide our patients with access to the highest quality of Foot Care available. In order for us to do so, we must ensure that we are able to meet our operational expenses. We ask that you read, understand and sign our Financial Policy prior to receiving treatment.

1. **I understand that it is my responsibility to pay any deductible, co-insurance amount, or any other balance not paid for by my insurance company or third party payor within a reasonable period of time, not to exceed sixty {60} days.**
2. **I understand that as of November 1st 2021, there will be a charge of $50.00 missing appointment {NO SHOW} and $25.00 cancellation appointment without 24 hour notice at the office.**
3. **It is your responsibility to ensure that our physicians are in your INSURANCE NETWORK.**
4. **If your plan requires a referral, IT IS YOUR RESPONSIBILITY TO OBTAIN THIS PRIOR TO BEING SEEN BY OUR PROVIDER.**
5. **You are ultimately responsible for payment of charges for services you receive from our office.**
6. **SELF-PAY Payment in full is due at the time of service if you do not have health insurance.**
7. **There is a service fee of $35.00 each time a check RETURNED. The bank may return your check up to three times before considering it non-negotiable. Your insurance company does NOT cover this FEE.**
8. **Medical Records request must be received in writing at least 72 hours prior the day needed.**
9. **You must inform the office of all-insurance changes and authorization, referral requirements. In the event the office is not informed, you will be responsible for any charged denied.**
10. **There are certain elective surgical procedures for which we require pre-payment. You will informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.**
11. **For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.**

WILLIAM J. NAMEN II D.P.M, P.A

PAYMENT AT TIME OF SERVICE

As a courtesy, we will bill your insurance for all services, however, we ask that you pay any portion of your cost not covered by your insurance due to deductibles, co-insurance or co-payments on the day of service. Billing for these items is not only costly, but our statements often go unpaid. This results in increased costs to both you and our other patients.

SUBMISSION OF CLAIMS

Your health insurance plan is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, charges not paid by your insurance company your responsibility. Working together, we can resolve most insurance company issues in a mutually acceptable manner, nevertheless, it is the patient's responsibility to understand his or her policy limitation. In the event your health insurance determines that they will not cover a service that you have received, you will be responsible for payment.

OUTSTANDING BALANCES

We urge you to keep your account current to avoid any misunderstanding with our office. When an account balance becomes more than 90 days past due, it will be referred to an outside collection agency. At that time, any additional fees incurred the account will be responsibility to patient. If you need to make special payment arrangements, it is your responsibility to contract one of our financial counselors before your account is sent to ana agency. Minimum monthly payment arrangements maybe made for no less then $50.00 unless approved by the Director of Finance. As a last resort, patients who fail to make payments could be terminated from the practices.

PAYMENTS OPTIONS

You will receive monthly statements. The amount shown in the "DUE FROM PATIENT"

Box is your financial obligation. It is due and payable upon receipt. For your convenience, we accept payment in the form of cash or check and from VISA, MASTER CARD, AMERICAN EXPRESS AND DISCOVER. Payments may be made by calling the number 904-636-9197, or mailed to 9310 OLD KINGS RD SOUTH STE 1201, JACKSONVILLE FL 32257.

BY SIGNING THE ABOVE, YOU AGREE TO ALL THE TERMS AND CODITIONS CONTAINED HEREIN

:

WILLIAM J. NAMEN II D.P.M., P.A.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

Patient Name _____

Parent or Legal Guardian of Child _____

Signature _____

Date _____

WILLIAM J. NAMEN II D.P.M., P.A.

PAIN MANAGEMENT AGREEMENT

- **I will be taking pain medication prescribed by Dr WILLIAM J. NAMEN II. This agreement is to help both you and Dr Namen comply with the law regarding controlled pharmaceuticals. I understand that this agreement is essential to the trust and confident necessary and a doctor or patient relationship and that Dr Namen undertake to treat me based on this agreement.**
- **I understand that I am being prescribed medication that has significant side effects that have been explained to me in detail. I understand that some medications will affect me while operating equipment such as driving a vehicle.**
- **I understand that if I break this agreement, Dr Namen will stop prescribing these pain-controlled medicines. In the case Dr Namen will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment may be recommended.**
- **I will communicate fully with Dr Namen about the character in intensity of my pain, the effect of the pain on my daily life, and have all the medicine that is helping to receive the pain.**
- **I will not use illegal controlled substances, including marijuana, cocaine etc. I will not consume alcohol {wine, beer or other alcoholic beverages} while taking this medications.**
- **I will not share or trade my medication with anyone.**
- **I will not attempt to obtain any controlled medicines, including pain medicines, controlled stimulants, or antianxiety medicine from any other doctor. I will safeguard my pain medicine from lost or theft. Lost or stolen medication will not replaced. I will not keep my medication any vehicle.**
- **I agree that refills on my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hour. No refills will be available during evenings or on weekend.**
- **I authorize Dr Namen and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state Board of Pharmacy, in the investigation of any possible misuse, sales or other diversion of pain medicine. I authorize Dr Namen to provide a copy of this agreement to my pharmacy.**

WILLIAM J. NAMEN II D.P.M., P.A.

- **I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this authorization.**
- **I agree to provide a list of all pain or other medications that I am presently taking to Dr Namen and agree to keep him up-to-date on any new medication that I am currently taking.**
- **I agree that I will submit to a blood or urine test if required by Dr Namen to determine my compliance with my program of controlled medicine.**
- **I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period time.**
- **I will bring all unused pain medicine to every office visit.**

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into this day of _____

Patient Signature _____

Physician Signature _____

Witnessed by _____

WILLIAM J. NAMEN II D.P.M., P.A.

PRESCRIBED MEDICATION AGREEMENT

I have provided to Dr Namen all of the medications that I am presently taking whether prescribed by another doctor or over the counter medications.

I understand that I am being prescribed medication that has significant side effects that have been explained to me detail which could affect me taking medication.

I understand that some medications will affect me operating equipment such as driving a vehicle.

I understand that I will not use any illegally controlled substances, including marijuana, cocaine etc.

I will not consume alcohol {wine, beer or other alcoholic beverage} while taking this medication.

I will safeguard my medicine from loss or theft at al times. I will not keep my medication in any vehicle.

I also understand that I will not share, sell or trade medications with anyone.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into this day of _____

Patient Signature _____

Physician Signature _____

Witnessed by _____