

**SHARI L. KAMINSKY, DPM, PC
JERRY M. LIDDELL, DPM
NOTICE OF PRIVACY PRACTICE**

I acknowledge that I have received a summary of Dr. Shari L. Kaminsky and Dr. Jerry M. Liddell's Notice of Privacy Practices and consent to the use of disclosure of my protected health information by Dr. Shari L. Kaminsky and Dr. Jerry M. Liddell for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills and to conduct health care operations as required by law.

I acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my Protected Health Information (PHI), as it is outlined in this notice. I am aware Dr. Shari L. Kaminsky and Dr. Jerry M. Liddell reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Office policies for Dr. Shari L. Kaminsky and Dr. Jerry M. Liddell

Co-payments:

Insurance co-payments are required at the time of service, we are required through our contract with your insurance plan to follow guidelines which states when you visit a specialist you must pay your co-pay in full at the time of you visit. You will be asked to reschedule you appointment if you are unable to pay your co-payment.

Appointment schedule:

If you are more than 15 minutes late for your appointment you may be asked to reschedule. There is a \$25.00 charge for appointments not cancelled 24 hours in advance.

Fees:

There is a \$40.00 fee for returned checks. There is a \$20.00 fee for completing paperwork such as FMLA and disability forms for each set requested. This must be paid before the forms are completed.

Referrals:

If your insurance plan requires a referral or pre certification for a specialist office visit, you are responsible for obtaining the referral and/or preauthorization prior to your appointment or you must reschedule your appointment.

Past Due Balance:

If your account becomes past due, we will take necessary steps to collect this debt, if we have to refer your account to a collection agency, you agree to pay a \$25.00 collection fee. If we have to refer you collection balance to an attorney, you agree to pay all attorneys' fees which we incur plus all court costs. In cast of suit, you agree the venue shall be in St. Louis County.

Insurance and Identification:

We need to make a copy of the front and back of your insurance card at your initial visit along with photo identification. We expect you to inform us of any change in coverage that may occur and provide us with an insurance card to copy at that time. If you have two or more insurances policies, it is your responsibility to inform us which policy is Primary (first) coverage, which policy is secondary (second) coverage, and which policy is tertiary (third) coverage. With each policy we will require the name, date of birth, address, phone number, and employer of the member who carries the policy. Patients will be required to periodically update your paperwork this is a requirement from your insurance company and your physician. This will include you address, insurance information, phone numbers and your medical history including medications. This information will allow your physician to properly treat your condition.

I have read and received a copy of the office polices of Shari L. Kaminsky, DPM and Jerry M. Liddell, DPM and understand it fully.

Patient signature: _____ Date: _____

Parent or Legal Guardian Signature (if patient is a minor): _____

Staff Witness: _____

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