Jenneffer Pulapaka, DPM, AACFAS, CWSP, DABMSP, FACCWS
DELAND FOOT AND LEG CENTER 844 N. Stone St., Ste 208, DeLand, FL 32720
Office: 386-738-3733 | Fax: 888-797-7472 | www.DelandPodiatry.com

PRACTICE PHILOSOPHY:
The focus of our practice is the treatment of lower extremity problems. To this end we are in partnership with you, and we require your full cooperation. Our commitment is to provide you with innovative medical care to the lower extremity. As part of our commitment to higher medical standards, our Center provides digital imaging, electronic medical records, and electronic billing. ***No paper originals or records are maintained.*** Should you encounter a lower extremity medical problem notify our office and/or leave a message. We are not an emergency room, but we can provide **QUICK CARE** for our patients during the Center's hours.

TREATMENT AGREEMENT:
I hereby apply for treatment by DeLand Foot and Leg Center, LLC. I consent to treatment with **Dr. Jenneffer Pulapaka and her team**. I consent to photographs, audio, or videotaping that may be taken for educational purposes or medial assessment. We use dictation and Artificial Intelligence (AI) dictation during all clinical documentation. These images or recordings may be preserved in your medical record.

ABOUT OUR FEES:
Our consultations and evaluation fees are lower than the usually considered reasonable and customary current year Medicare Fee Schedule. Some insurers, however, may reimburse based on an arbitrary schedule of fees which bears no relationship to our standard of care, or they will not cover cosmetic procedures entirely. It is the patient's responsibility to understand their coverage and the details of their insurance policies.

CANCELLATION POLICY:
DeLand Foot and Leg Center, LLC requires a **48-hour cancellation notice**. We ask your full cooperation not to burden you. If your appointment is on Monday morning you can call Saturday to cancel. You may leave a message with our service when calling the office after hours. A **$75.00 fee** applies for appointment cancellations in less than 48 hours. A **$250.00 fee applies for surgery canceled** in less than 48 hours.
Initials: _____

FINANCIAL RESPONSIBILITIES:
All Payments and Co-payments Are Due at the Time Services Are Rendered. We accept checks, cash, MasterCard, Visa, and Discover. Any returned checks will incur an additional processing fee of $35.00 each. Fees not paid within 60 days of the date of services shall be subject to a finance charge of 1.75% per month or $3.00 per month, whichever is larger. In the event, your account goes into collections the entire collection fee will be added to your balance. Our office does submit delinquent accounts to reporting credit bureaus.
We accept credit and debit cards. A 3.6% convenience fee is applied to all credit and debit card transactions. If you prefer to avoid this fee, we are happy to accept cash or check for your payment. Please confirm you understand.

INSURANCE INFORMATION:
We do participate with specific insurance companies. In case we are not a participant/provider with your insurance company, we will provide you with a receipt which includes the doctor's signature, diagnoses and description of services and fees. You may submit this to your insurance company**. You are responsible for all interactions with your out of network insurance company. Our staff is not trained to deal with every insurance company's particular issues.** Your insurance company has a contract with you and/or your employer, not with us. You have the right to demand an explanation for any decision they make. **WE WILL SUBMIT TO YOUR CO-INSURANCE ONE TIME, AS A COURTESY TO YOU. AFTER WHICH, ANY AND ALL DENIED OR UNPAID CHARGES BECOME YOUR RESPONSIBILITY.**

Medicaid does not pay your primary insurances' co-pay or balance. I understand and agree that **regardless of my insurance status**, I am ultimately responsible for the balance of my account for any and all professional services rendered. I furthermore agree to notify the DeLand Foot and Leg Center, LLC on any changes in my insurance or health status. **Initials:** _____

I understand that my eligibility for coverage may not be defined at this time, and it is my sole responsibility to understand my insurance policy. Furthermore, it is my responsibility to notify the office of any change to my medical coverage. If wish to receive medical service from DeLand Foot and Leg Center, LLC, and it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

ADDITIONAL POLICIES:
- **Prescription Refill** requests take 48 hours to process, so please allow adequate time for us to fill your request.
- **Disability, Insurance, and/or Medical Forms** requests usually take 5-7 days to complete after the $35.00 processing fee has been paid for each packet.
- **Lab results**: it is the patient's responsibility to follow through on their care and request a copy of the results or all labs or testing performed in the office or out of the office, i.e. MRI, Bone Scan, and Pathology.

This is a notice to all patients, we are a practitioner that participates in the Florida Prescription Drug Monitoring Program, known as E-FORCSE® .

My signature below attests that I have read and understood all of the information contained herein and agree to abide by the above Office Policies set forth by DeLand Foot and Leg Center, LLC.

- Signature of Patient or Patient Authorized Representative: _____

- Date: