Plymouth Podiatry Policies and Procedures

At Plymouth Podiatry our patient's time is very important; we strive to get every patient in on time as scheduled. We expect all patients to be courteous to others and be on time to their scheduled appointment so we can continue serving all patients on time. As we do all we can to be sure you are seen at your scheduled time, there may be events or emergencies that create our doctors to run behind slightly. In these events, we will do our best to keep the doctors on time as your time is valued. We give each patient a five-minute window to be seen at their appointment time, as we do understand at times you may not be able to make that time. If you are more than 5 minutes late, we will need to reschedule your appointment.

We do advise all patients to contact our office 24 hours in advance if unable to make your scheduled appointment to avoid any charges. If you do not show for your appointment, you will be billed $50 and will need to pay this charge before being seen for any further services. New Patients to our office will be billed $100 if they do not show for their initial evaluation.

Even though we accept most insurances, this does not mean that all services are covered, and your insurance carrier may deem your visit "patient responsibility" toward any deductible, if applicable. Our office is unable to preemptively determine any outcome from your insurance company. In this case, once the insurance company has made amount "patient responsibility", this does now become the patient's responsibility. Contacting your insurance company will be the best way to resolve any issues. Although we cannot change the outcome of your claim, we would be happy to guide you in the right direction.

All Patients under 18 must be accompanied by a parent/legal guardian at all scheduled appointments.

By signing this form, you are allowing treatment from

Dr. Michael Skonieczny DPM, Dr. Sherree Smith DPM, or Dr. Erik Henriksen DPM

____ ____

Printed Name **Relationship to patient**

(If signing as a personal representative to patient)

____ ____

Signature **Date**

Please state below the names and relationships of whom you wish to allow your medical information to be shared.

____ ____

Name **Relationship to patient**