ANKLE & FOOT ASSOCIATES

ORANGE PARK, JACKSONVILLE BEACH, ST. AUGUSTINE

NO SHOW AND LATE CANCELLATIONS

Due to increasing cost and complexity of regulations we have found it necessary to charge for a "no show" and for "cancellations" made with less than 24 hour notice. This will be **a $50.00** fee. It will be your responsibility to obtain the name of the person you called and the date/time in which you cancelled to avoid this fee. Remember this is a **24** hour notice.

REQUESTED FORMS TO BE COMPLETED

Disability Forms to be completed require a prepayment of $25.00 each time new information is requested. The first FMLA form is free after that the 25.00 charge applies. Leave the form with us and allow 7-10 business days for completion. If you require forms to be completed by Dr. Tellam you MUST FIRST complete all information concerning you, your job, work duties,etc. Disability paperwork will not be completed until after surgery.

RECORDS & X RAY REQUEST

Copies of medical records requested by the patient: First copy will be provided free after that in accordance with FAC 64B8-10.003 the price is $1.00 per page up to 25 and $0.25 per page for the remaining. **Allow 7-10 business days** for the retrieval and copying of records. Do not ask us to copy your records "on demand" or with little to no notice. We recommend if obtain your records from us you make copies so that you have them as needed.

Copies of any x rays will require you to bring a CDR in and **allow 7-10 business days** for the x-ray image to be retrieved and burned onto the CDR. Once again please do not call us the day you need them or with little notice. We have three locations and are not at each office daily to retrieve them.

PHOTO/VIDEO/AUDIO

Patients, family members, visitors are not to video, record, tape, photo any procedure, appointment or anything transpiring in the office without the expressed consent of Dr. Tellam. You MUST ask him and receive his approval prior to any/all media usage.

INSURANCE APPEALS

Occasionally we need to appeal a visit/procedure/item with your insurance company. This requires your consent in order for us to work on your behalf. UNLESS OTHERWISE NOTED HERE_____YOUR SIGNATURE ON THIS DOCUMENT IS YOUR APPROVAL/PERMISSION FOR US TO DO APPEALS ON YOUR BEHALF FOR INSURANCE NON PAYMENTS.

_____ _____

Patient PRINTED name Patient/responsible party signature and date

Please let us know if you would like a copy of this policy.

NS 4-19