INDY PODIATRY
we love your feet
Dr. Michael J. Helms
Dr. Kellie Higgins
Dr. Rachel Chhiba

PODIATRISTS
FOOT SPECIALISTS

Office: **(317) 573-4250**
Fax: **(317) 573-4253**
www.indypodiatry.com

9240 North Meridian St. Suite 260, Indianapolis, IN 46260
11530 Allisonville Rd. Suite 100, Fishers, IN 46038

Helms Podiatry, LLC
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Helms Podiatry, LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Helms Podiatry, LLC for providing podiatry services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Helms Podiatry, LLC. I understand I am responsible for the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Helms Podiatry, LLC. I agree to pay Helms Podiatry, LLC the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

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Consent for Treatment

I hereby authorize the doctors of Helms Podiatry, LLC, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to the appointment you are cancelling.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Helms Podiatry, LLC will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____