



# Westside Podiatry Group, LLC

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## OFFICE FINANCIAL POLICY

Our financial policy has been set up to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying for their medical care.

1. Full payment is expected at the time of service unless other arrangements are made. There will be an additional charge of \$10.00 for copayments not made at the time of the visit.
2. A service charge of \$5.00 per month on the unpaid balance will be charged after 30 days.
3. If an appointment is broken and not canceled, a charge of \$48.00 will be applied to your account.
4. Returned checks are subject to a \$20.00 service charge and will terminate your privilege to pay by check in the future.
5. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agent or attorney for recovery, that the patient will be fully responsible for any costs, including, but not limited to attorney's fees.

## RELEASE OF INFORMATION AND HIPAA SIGNATURE:

I hereby authorize Westside Podiatry Group to release all information regarding services rendered to my insurance company/Medicare, keep my signature on file, and to accept third-party payments from my insurance company. However, I agree to take financial responsibility for co-payments, deductibles, and any amounts not covered by my insurance company.

I acknowledge that I have had the opportunity to read the Privacy Practice Act located in the reception area, and I understand the notice.

**Please sign below to indicate you have read the above Office Financial Policy section and the Release of Information and HIPAA section and understand them fully.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

GREECE OFFICE  
2236 RIDGE ROAD WEST  
ROCHESTER, N.Y. 14626  
(585) 225-2290  
FAX (585) 225-1367

GATES-CHILI OFFICE  
507 BEAHAN ROAD  
ROCHESTER, N.Y. 14624  
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