

This document constitutes a binding legal agreement between the Doctors ("the Doctors") of San Mateo Podiatry Group ("the Practice") and the patient (or legally responsible party). Please review these terms carefully prior to signing.

- 1. The Doctor-Patient Relationship.** Once a doctor-patient relationship is established, the Doctor works directly and exclusively for the patient to deliver the best possible care in exchange for prompt and timely payment.
- 2. Doctors are licensed to practice medicine; insurance companies are not.** We believe the Doctor-Patient relationship must remain sacred and uncompromised by health insurance company guidelines, prior authorization barriers, or cost-containment restrictions because:
 - a. No License to Practice Medicine.** Health insurance companies, corporate claims administrators, and government program bureaus are not licensed to practice medicine and have no clinical or ethical duty of care regarding your individual health outcomes.
 - b. The Payer Conflict of Interest.** Insurance companies and Government Social insurance entitlement programs frequently operate under an intrinsic conflict of interest regarding healthcare expenses.
 - i.** Commercial insurance companies have a primary fiduciary duty to shareholders to maximize profit, which is achieved by minimizing the "Medical Loss Ratio" (the percentage of premiums spent on actual patient care).
 - ii.** Government programs face intense pressure from national deficits and budgetary constraints, creating an incentive to prioritize administrative cost-containment over optimal clinical outcomes.
- 3. Patient Responsibilities**
 - a. Clinical & Financial Responsibilities**
 - i. Treatment Adherence:** You agree to follow prescribed treatment plans, attend scheduled appointments, and complete home care protocols. Failing to follow medical advice directly harms your clinical outcome and adversely impacts your right to dispute treatment results or related billing.
 - ii. Payment at Time of Service:** All copays, deductibles, and cash fees are due when care is delivered. Professional services rendered create an immediate, binding financial obligation.

- iii. **Insurance Cooperation:** You are responsible for responding promptly to any requests from your insurance carrier (such as Coordination of Benefits or accident questionnaires). If your insurer denies a claim because you failed to respond to them, you become immediately responsible for paying the full cash balance.
- iv. **Elective Care Standard:** Outside of hospital emergency rooms, an outpatient practice is under no legal obligation to provide free or ongoing medical services without an active, verified payment arrangement.

b. Transparency, Second Opinions, and Concurrent Care

- i. **Accurate Medical History:** You must provide a complete and truthful medical, surgical, and insurance history. Providing false insurance information or hiding relevant health history undermines your care and voids your standing in any financial or clinical dispute.
- ii. **Second Opinions vs. "Doctor Shopping":** We fully support your right to seek a formal second opinion to make informed decisions about your health. However, seeking concurrent treatments, duplicate procedures, or conflicting prescriptions from another Doctor ("Doctor Shopping") creates severe medical risks and breaks clinical trust. We reserve the right to terminate the doctor-patient relationship and withdraw from your care in such circumstances.

4. Patient Affirmation & Consent

- a. **Completeness and Accuracy:** I affirm that my medical history answers are accurate to the best of my knowledge. I will inform the doctor and staff of any changes in my health status.
- b. **Treatment Consent:** I consent to the Doctors performing necessary evaluations, diagnostic exams, and minor procedures to treat my condition or injuries. I also consent for my minor child/children or family members for whom I am legally responsible.
- c. **Medication History:** I consent to the Practice accessing, reviewing, and downloading my prescription medication history from electronic databases.
- d. **Emergency Care:** I understand and agree to call 911 or visit the nearest emergency room for any active medical emergencies, and follow emergency personnel directions.

5. Communications and Appointments

- a. **Electronic Communications:** I consent to be contacted by phone, email, and text based on my preferences. I understand that standard electronic communications may not be encrypted or secure, and I waive any associated privacy requirements. All such communications may become part of my permanent medical record.
- b. **Office Reschedule and Cancellations:** We ask that you help us maintain an efficient schedule by keeping scheduled appointments and providing advance notice if you cannot attend. Patients who fail to arrive within fifteen (15) minutes of their scheduled appointment, or who reschedule or cancel with less than 72 hours' notice, will be charged an office cancellation fee of \$150.00 directly to the credit card on file.

6. Treatment Protocols and Acceptance of Risk.

This section outlines the financial terms and acceptance of risk for all treatments provided by the Practice, including office procedures, surgical services, and prepaid treatment packages.

- a. **Financial Responsibility for Delivered Care.** Fees are charged for professional skill, clinical time, diagnostic evaluations, specialized equipment reservation, and medical procedures delivered—not for a specific guaranteed clinical result. All delivered services remain fully payable. Unsatisfactory clinical progress, partial resolution, or the need for secondary/adjunctive care does not constitute a failure of service delivery or a financial billing error and does not entitle the patient to a refund or financial credit.
- b. **Absence of Guarantee.** I understand and accept that medical and surgical treatments are not an exact science and carry inherent physiological variability. The Doctor and Practice may quote clinical success rates based on peer-reviewed research, but I acknowledge that these statistics apply to populations, not individuals, and my specific outcome may vary. The Doctor and Practice make no explicit or implied guarantee of a specific cure, outcome, or percentage of pain reduction resulting from any treatment, minor procedure, surgery, or protocol.

7. Financial Policy & Payment Terms

- a. **Benefits Check:** A complimentary benefits check is available upon request to help you understand your insurance cost-share, deductible, and out-of-pocket amounts.
- b. **Good Faith Estimates:** Under the federal No Surprises Act, good faith estimates are provided to uninsured or self-pay patients who receive scheduled, non-emergency health care services. These estimates apply to both emergency and non-emergency care booked at least 3 business days in advance, or requested directly, across all licensed healthcare providers and facilities (including physicians, therapists, clinics, and hospitals). **Exclusions:** Good Faith Estimates do not apply to

beneficiaries of federal government entitlement social insurance programs, such as Medicare, Medicaid, or VA health care.

- c. **Payment Policy:** You agree to pay for the services you receive. Payment is due in full at the time of service. We will submit charges to insurance plans that contract with us. All cost-share amounts (co-pay, co-insurance, and deductibles) are due at the time of service.
- d. **Credit Card on File (COF):** We keep credit cards securely on file for your convenience. All outstanding balances due at thirty (30) days will be automatically charged to the card on file, with itemized receipts sent via email.
- e. **Cash / Prompt-Pay Discounts & Transparency (BPC § 657):** In compliance with California Business and Professions Code § 657, the Practice may grant prompt-payment discounts or cash-pay rates to uninsured or self-paying patients. Any discounted fee granted under this section is designed to facilitate affordable access and shall not be deemed to represent the Practice's usual, customary, or reasonable (UCR) fee for commercial insurance billing or other purposes.
- f. **Third-Party Patient Financing & Credit (BPC § 654.3):** Before enrolling a patient in a third-party credit program or patient loan (such as CareCredit or other deferred-interest medical financing), the Practice must provide an itemized written treatment plan with clear estimated costs for each anticipated service. In compliance with California Business and Professions Code § 654.3, credit applications cannot be completed while a patient is in a treatment room or surgical area. Any unearned funds received from a third-party lender for unrendered services must be refunded to the lender within fifteen (15) business days of a patient's request.
- g. **No Retention of Duplicate Funds:** In accordance with California Business and Professions Code § 732, if both the patient and your insurer pay the Practice for the same service, resulting in a duplicate payment, we will refund you within thirty (30) days. Conversely, if your insurer pays you directly for services rendered by the Practice, you have an absolute legal and ethical duty to immediately sign over and remit those funds to the Practice.

8. The True Scope of Health Insurance. In the United States, private health coverage and federal social insurance are anchored by three primary statutes:

- **Employee Retirement Income Security Act of 1974 (ERISA): 29 U.S.C. §§ 1001–1461**
- **Affordable Care Act (ACA): 42 U.S.C. § 18001 et seq.**
- **Medicare: Social Security Act, Title XVIII**

- a. Historically, legally, and actuarially, health insurance is designed strictly as a catastrophic safety net for major, unpredictable medical crises—not a pre-paid subscription for lifelong healthcare;

It was never intended to fund routine ambulatory or outpatient services from birth to death. Attempting to run predictable, routine, or specialized outpatient care through a third-party payer mechanism inevitably creates massive administrative friction, inflated operational overhead, and severe double moral hazard.

- b. “Insurance coverage” is not a guarantee of payment.** “Coverage” is a term that, in the context of insurances, is a financial risk tool that Insurance uses to select the services that it will and will not consider for payment under the terms of your insurance policy.
- c. The Cost-Share Obligation.** Every health insurance plan requires some form of patient cost-sharing. Patients always maintain a primary contract with their insurer that mandates out-of-pocket responsibilities, including **deductibles, copayments & coinsurance, and non-covered services.**

9. Limited Power of Attorney for Health Insurance Matters

- a.** To ensure the Practice can effectively advocate for coverage and reimbursement on your behalf, for the duration of your relationship and associated billing period, you hereby appoint San Mateo Podiatry Group (and its designated billing agents and attorneys) as your true and lawful attorney-in-fact (your "Agent").
- b. Scope of Authority:** This Limited Power of Attorney grants my Agent full authority to act in my name, place, and stead regarding my health insurance coverage, including:
 - i. Claims & Appeals:** Submitting claims, receiving explanations of benefits (EOBs), and pursuing all administrative appeals for denied, underpaid, or retroactively denied claims.
 - ii. Regulatory Complaints:** Filing official grievances or complaints with state and federal regulatory bodies (such as the California Department of Managed Health Care, the California Department of Insurance, or the federal Department of Labor) if my insurer fails to pay or delays payment improperly.
 - iii. Information Access:** Demanding and receiving all documents related to my health plan (including Summary Plan Descriptions, medical policy guidelines, and claim file records), overcoming standard HIPAA barriers as an "authorized representative".
 - iv. Legal Action:** Taking necessary legal steps to enforce payment of benefits directly to the Practice.

- c. **Durability:** This power is "coupled with an interest" (the financial interest of the Practice in getting paid) and shall remain in effect until all account balances associated with my care are paid in full.
- d. **No Waiver of Responsibility:** This authorization empowers the Practice to fight for payment but does not relieve me of my primary financial responsibility to pay for services rendered if the insurance company ultimately fails to pay.

10. Health Insurance Recoupment

- a. **Recoupment Responsibility and Risk Period:** Health Insurance companies have up to one year (365 days) from the date of payment under California law AB 1344 (amending BPC § 10113.6) to dispute, recoup, or void a prior claim payment. Due to this risk, the patient remains financially responsible for any and all funds that the insurance company subsequently recoups, voids, or requests back from the Practice.
- b. **Authorization:** In the event of an insurer recoupment or clawback, I authorize the Practice to immediately charge the outstanding balance to my Credit Card on File.
- c. **Cost of Enforcement:** If the Practice must employ an attorney or collection agency to recover these recouped funds, I agree to pay all reasonable legal fees and collection costs incurred by the Practice in addition to the original balance.
- d. **Credit Confirmation Trigger:** An account credit is confirmed and becomes available only after all insurance claims related to that service have been fully processed, paid, and deemed final by the Practice, and the statutory recoupment risk period has reasonably passed.

11. Refund and Credit Policy

- a. This section governs all refunds, prepaid fees, overpayments, and credit balances.
- b. **Duplicate Payments & Overpayments (BPC § 732):** In compliance with California Business and Professions Code § 732, if both the patient and a third-party payer (insurance plan) pay the Practice for the same medical services, resulting in an overpayment or duplicate credit balance, the Practice will refund the duplicate payment amount to the patient within thirty (30) days of the patient's request (or within 30 days of the duplicate payment being finalized and reconciled).
- c. **Patient Account Credit Option:** Once an account credit is confirmed and reconciled (and the recoupment risk period has passed), the patient will be notified in writing and given the choice to either:

- i. Receive a refund of the credit amount within 14 business days of the written request, or
- ii. Keep the balance as an account credit to be applied to future financial responsibilities.
- iii. If no selection is communicated within 30 days of written notification, the balance will remain on your account as an active credit available for future services or refund upon request.

12. Self-Pay Treatment Package Cancellation & Refund Policy

- a. **Scope & Self-Pay Exclusivity:** Treatment packages offered by San Mateo Podiatry Group are voluntary, bundled, cash/self-pay agreements designed for comprehensive, multi-session care. Packages are independent of third-party health insurance, and due to insurer policies, cannot and will not be billed to health insurance.
- b. **Voluntary Discontinuation:** You retain the right to discontinue your treatment package at any time by providing written notice to the Practice.
- c. **Refund Calculation for Unrendered Care (Pro Rata Refund Policy):** If you discontinue a package prior to completion, any refund for unrendered care will be calculated based on the unused portion of your prepaid package balance pro-rata under the following terms:
 - i. **Valuation of Rendered Services:** Completed visits and clinical therapies will be calculated and billed using the standard pro-rated package per-unit rate.
 - ii. **Custom Devices & Specialized Diagnostics:** Custom-fabricated appliances (e.g., custom foot orthotics, custom braces), specialized surgical/procedural supplies, and completed diagnostic scans are deemed 100% rendered once casted, ordered from our laboratory, or performed. Their specific package value is non-refundable and will be deducted in full from the prepaid balance.
 - iii. **Deduction of Unrecoverable Third-Party Transaction Fees (Credit Card & Financing Fees):** Any refund issued under this section is subject to a full deduction of the actual, non-refundable transaction fees charged by third-party processors. Because credit card merchant networks (e.g., Visa, Mastercard, AMEX, Stripe) and patient financing lenders (e.g., CareCredit) permanently retain their interchange and merchant discount fees (typically 2.5% to 3.5% for standard credit cards, and 15% or more for specialized patient financing) upon the processing of a transaction and do not return these fees to the Practice when a refund is issued, these represent an unrecoverable out-of-pocket transactional loss directly caused by the patient's voluntary cancellation. The Practice will deduct these actual, unrecoverable transactional fees in full from any refunded amount.

- iv. **Tiered Administrative Cancellation Fee:** To cover the substantial administrative and clinical overhead involved in dismantling a clinical protocol—including clinical chart auditing, medical prescription reconciliation, inventory/specialized-sterile-supply re-shelving, scheduling adjustments, and merchant settlement auditing—a tiered Administrative Cancellation Fee will be deducted from the unused balance based on the original total package price:

1. Packages up to \$2,500.00: A flat fee of \$250.00 will be deducted.
2. Packages from \$2,501.00 to \$5,000.00: A flat fee of \$500.00 will be deducted.
3. Packages over \$5,000.00: A flat fee of \$1,000.00 will be deducted.

d. Remittance & Balance Settlement:

- i. **Credit Refunds:** Any remaining net credit balance will be refunded via the original payment method within 30 days of receiving your written cancellation request (or within 15 business days if funded via third-party financing per BPC § 654.3(f)).
- ii. **Outstanding Balances:** If unbilled services delivered or ordered prior to cancellation create an outstanding balance, an itemized statement will be provided to you at least three (3) business days prior to processing any payment or utilizing a credit card on file.

13. Surgical Scheduling Reservation Deposit & Non-Refundability Agreement

- a. To reserve a surgeon's dedicated surgical block time and coordinate the intensive administrative and clinical preparation required for surgery—including operating room (OR) facility booking, anesthesia coordination, surgical assist scheduling, and specialized hardware/sterile implant preparation—the Practice enforces the following deposit policy:
- b. **Surgical Reservation Deposit:** A deposit of \$1,000.00 is required at the time of surgical scheduling to secure your OR date and time slot.
- c. **Approved Payment Methods:** Surgical deposits must be paid directly via cash, cashier's check, bank transfer, or major personal credit card (Visa, MasterCard, AMEX). The Practice does not accept third-party medical credit cards, healthcare loans, or deferred-interest financing (e.g., CareCredit) for initial surgical deposits.
- d. **Application of Funds:** This deposit is not an administrative penalty or surcharge. The entire \$1,000.00 will be credited directly toward your out-of-pocket surgical responsibility (such as insurance copays, deductibles, coinsurance, or self-pay balances) once the surgery is performed.

- e. **Liquidated Damages & Non-Refundability:** By paying a surgical deposit, you acknowledge that the Practice immediately incurs non-recoverable administrative labor, orders specialized supplies, and commits exclusive Ambulatory Surgery Center (ASC) operating room block time on your behalf.
- f. **Pursuant to California Civil Code § 1671(d), all patient-funded deposits are 100% non-refundable for any patient-driven cancellation, failure to appear, or short-notice rescheduling request made less than thirty (30) calendar days prior to the scheduled procedure.** Rescheduling requests made with thirty (30) or more calendar days' advance notice permit 100% of the deposit to transfer directly to a new surgical date scheduled within six (6) months, while remaining strictly non-refundable in cash.
- g. The Practice will make reasonable best efforts to accommodate your preferred scheduling window, however all future dates remain strictly subject to physician, surgical staff, and facility block availability and cannot be guaranteed.
- h. You agree that any retained deposit under this section constitutes a fair and reasonable liquidated damage representing the Practice's actual administrative and idle-capacity losses, which are impracticable to quantify at the time of scheduling.
- i. **Mandatory Exceptions to Non-Refundability:** Your deposit will be refunded solely under the following **two (2)** conditions:
 - i. **Practice Cancellation:** The Practice reschedules or cancels your surgery for non-patient administrative or clinical reasons (**Civil Code § 1689**). In this event, 100% of your deposit will be refunded.
 - ii. **Medical Ineligibility:** You fail mandatory pre-operative clinical clearance or are determined medically unfit for surgery by your primary care Physician, the Anesthesia team, or another specialist in the course of medical clearance prior to the procedure (**BPC § 2234**). In this event, your deposit will be refunded net of non-recoverable merchant credit card processing fees.

14. General Provisions

- a. **Assignment of Benefits and Release of Information:** I authorize the Practice to act as my representative for all matters with my health insurance plans. I authorize the release of necessary medical information to submit and process claims, and I assign to the Practice all payments and benefits of my insurance policies for services rendered.

- b. Termination:** Either party may end this agreement at any time by giving written notice. In the event of termination, the Practice will settle your account by charging the Credit Card on File for outstanding balances. Patients will be provided secure electronic access to their clinical file to facilitate transfer of care.
- c. Amendment:** The Practice reserves the right to modify, amend, or update this Patient Engagement Agreement & Financial Policy at any time without prior notice. I understand that the version of the Policy in effect on the date I receive services will govern the terms of my agreement.

15. Patient Acknowledgement and Electronic Signature

- a. Incorporation of Terms:** By electronically signing below, I certify that I have read, reviewed, and fully understand all terms, conditions, and disclosures contained on all pages of this agreement, which I understand constitutes a single, integrated legal contract.
- b.** I have received, read, understand, and agree to the Notice of Privacy Practices (HIPAA), Podiatric Medical Board of California Notices, and Medicare Open Payments Database information (all available upon request and on the Practice website).
- c. Legal Intent of Electronic Signature:** Pursuant to the California Uniform Electronic Transactions Act (Civil Code § 1633.1 et seq.), I agree that my electronic signature below carries the same legal weight, validity, and enforceability as an original hand-written ink signature. I confirm that I have been provided the opportunity to download, print, or save a copy of this complete multi-page agreement for my records.

Electronic Signature, Next Page