NORTHEAST FOOT CARE, PLLC
5010 State Hwy 30 Suite 106
Amsterdam, NY 12010-7532

518-842-2200

Office Policies

As a service to you, we will bill your insurance carrier directly, and await their portion of payment due on your physicians services account. You will be responsible for paying any portion of the bill that the insurance company states is your responsibility. We accept cash, credit cards, checks and Care Credit.

- Copays and deductibles are due at the time of service as required by your insurance carrier. Failure to bring copay or deductible will result in rescheduling appointment.
- Any service that is not covered by insurance or is considered "self-pay" requires payment in full at time of service.
- There will be a $35.00 fee for all returned checks.
- If your insurance requires a referral, you will be responsible for obtaining the referral and bringing it to your scheduled appointment. If you do not have required referral, you will be asked to sign a waiver and will be responsible for the bill in full or we will reschedule your appointment.
- Your insurance policy may not pay for two or more totally unrelated surgical services that are provided on the same date of service, or they will not pay an office visit on the same date of service as a procedure. It is for this reason that we may have to schedule an additional appointment for another day to go over the other problem(s). We are sorry for this inconvenience, but your insurance has dictated these guidelines.
- We are not responsible for any incorrect information given to us by your insurance company.
- Please be aware that your insurance company may send letters and/or checks for physician services to you throughout your care. You are responsible for forwarding these items to us.
- When requesting prescription refills, please allow up to 24 hours to process your request.
- We request a 24 hour prior notification for rescheduling or cancellation of appointments.
- Only payment plans signed and approved by Dr. Lambarski are considered valid.
- All minors, under 18, must be accompanied by a parent/legal guardian for initial visit. Subsequent visits may be accompanied by written permission from parent/guardian only for another adult over 18 years of age.

Routine Release of Information and Assignment of Benefits

- Unless otherwise specified, I authorize NORTHEAST FOOT CARE, PLLC to release any records, reports, radiographs, and any other information requested by an insurance company, hospital, medical provider, health center, physician and/or any of my family members.
- I authorize the payment of benefits to supplier for physician services rendered.
- I have been told that I will ultimately be responsible for any part of my physician services bill not covered by my insurance carriers. I understand this information will be shared only with authorized persons and will be considered strictly confidential.
- I have read, understand, and agree to abide by all of the above guidelines and information.

Name: ______________________

Signature: _____________________