

Financial Policy

Please read thoroughly before signing:

Thank you for choosing us as your podiatric medical care provider. We are committed to providing you with quality and affordable health care. Please read our financial policy and sign in the space provided. A copy will be provided to you upon request. Feel free to ask any questions you may have.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate in, payment in full is expected at each visit. If you are insured by one of our participating plans but cannot show proof of coverage with an up-to-date insurance card, payment is required at the time of your visit, until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments, deductibles, and unpaid balances. All copayments, deductibles, and unpaid balances must be paid at the time of service. Collecting copayments and deductibles from patients at the time of service is our contractual obligation with your insurance company. Please assist us by paying your copayment and unpaid balances at each visit.

3. Non-covered services. Please be aware that some services you receive may be considered non-covered by Medicare or other insurers. This does not mean that the services aren't warranted, only that your insurance company may not provide these services as benefits under your type of plan. If your insurance company does not provide these benefits, you are responsible for these services provided.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or photo identification card and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of claims submitted on your behalf.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. **Your insurance benefit is a contract between you and your insurance company**, and is not a guarantee of payment.

6. Coverage and address changes. If your insurance and/or address changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over **90 days past due**, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency which may have a negative impact on your credit.

8. No show / missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours. A \$50 fee will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Financial Policy

(continued)

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

Printed name of patient or responsible party