

FINANCIAL POLICY

Thank you for choosing-us as your Foot & Ankle care Provider.

Please review and sign the following Financial Policy.

Please direct any questions or concerns to the Finance Manager.

Full payment is expected at the time of service unless other arrangements have been made prior to your visit.

We accept cash, checks, and credit cards (MasterCard and Visa)

PRIVATE INSURANCE

Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. If your policy deems a particular service as non-covered, it is your responsibility to discuss with your insurance carrier why the service would not be covered. We do not alter treatments based on what your insurance policy covers or does not cover. This office will file all insurance claims with your insurance companies for you. Your bill with the physician however, is ultimately your responsibility regardless of insurance payment. It is your responsibility to provide the office with current insurance billing information.

UCR (Usual and Customary Reimbursement)

We have taken great care in determining our fees. Our charges accurately reflect the level of skill, complexity and expertise for this geographical area. If your insurance company's fee schedule falls below the level of our charges, you will be responsible for the difference. (Unless we have a written contract with your insurance company.)

MEDICARE PATIENTS (if applicable)

We do participate with Medicare. This means that you will be responsible for your 20% of the approved Medicare fee, any yearly deductible amounts, and payment in full for any non-covered services. Non-covered services include some services that Medicare deems not medically necessary.

MINOR PATIENTS (under 18)

Minors must be accompanied by parent or guardian. The Consent to Treat Minor Patients authorization form needs to be completed by the parent or legal guardian before treatment is provided.

MANAGED CARE CONTRACTS

We are currently participating in "Managed Care" (PPO, HMO, PHO) programs. If your policy requires a referral for services from your primary care physician, it is your responsibility to make sure that you provide a referral at the time of service. You will be responsible for all co-pays, deductibles, and non-covered services.

COLLECTION FEE RESPONSIBILITY NOTICE

In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I/we agree that in event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

WORKERS' COMPENSATION

We require authorization from your employer for all workman's compensation claims. We will file all claims with your company's workman's compensation carrier. In the event that the workman's compensation is disputed, you will be responsible for payment in full.

RETURNED CHECKS

A service fee of \$30.00 will be assessed for each returned check.

DUPLICATION OF MEDICAL RECORDS

A duplication fee may be charged up to an amount allowed by state law.

IF YOU HAVE ANY QUESTIONS REGARDING OUR PARTICIPATION WITH A SPECIFIC INSURANCE COMPANY PLEASE SEE THE FINANCE MANAGER.

I have read and understand my financial responsibilities under this policy.

Patient/Parent

Signature: _____ Date: _____