

PREFERRED FOOTCARE OF MUNCIE, LLC FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. **PREFERRED FOOTCARE OF MUNCIE, LLC** accepts cash, personal checks (in-state only), VISA, Discover and MasterCard. There is a service charge for returned checks of \$35.

Patients with an outstanding balance 90 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality. We will work with you to keep your account in good standing. For every statement sent after account is 90 days past due there will be a charge of \$5. Disability forms have a fee of \$10 to be paid before form is completed.

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.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

If you need assistance or have questions, please contact **The Billing Coordinator between 8:30 a.m. and 4:00 p.m., Monday through Friday at 765-284-4220.**

REFUNDS:

Patient/guarantor credits in amounts less than \$20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts \$20.00 and greater will automatically be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the **PREFERRED FOOTCARE OF MUNCIE, LLC** Financial Policy. I agree to assign insurance benefits to **PREFERRED FOOTCARE OF MUNCIE, LLC** whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or Authorized representative: _____

Date: _____

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