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Physician of Podiatric Medicine and Surgery

Patient Financial Policy

We are dedicated to providing the best possible care for you. Please understand that payment for services is considered part of your treatment. We ask that you read, agree to and sign this policy prior to treatment.

Co-pays and Balances

The patient is expected to present a valid insurance card at each visit. All co-payments and patient balances are due at the time of service unless arrangements have been made in advance. We accept cash, credit card or check. A $10.00 service charge is added to accounts when the co-pay is not paid at time of service. There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Participating Insurance Plans

Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor (in other words, if you agree to have your insurance companies pay the doctor directly). If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. A maximum of two plans will be billed. You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

We will bill your insurance company for all services provided in the office. **You are responsible for any balance due**. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Referrals

If your insurance has a designated primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit in order to receive maximum benefits. If an authorization/referral is not provided at the time of service, you will be asked to either reschedule your appointment or pay for the visit at the time of service.

Self-pay Accounts

Payment is required at the time of service for all services. Self-pay accounts are:

- Patients without insurance information on file.
- Patients without an insurance card at the time of service.
- Patients who are covered by an insurance that the practice does not participate in.

Non-participating Insurance Plans

The financial obligations of patients who are insured by carriers that the practice does not participate with are considered a self-pay account. If you are insured by a plan that we do not have a prior arrangement with, as a courtesy we will prepare a claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

Divorce & Child Custody Cases

In cases of divorce, the individual who receives the care is responsible for the payment of co-pays, coinsurance, and non-participating insurance balances at the time of service. The practice will not bill a divorced spouse for the patient's services. The parent with primary custody is usually the parent with whom the child lives and usually brings the child for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating, or non-participating insurance. If the non-custodial parent carries the insurance on the child, the office will bill that insurance company. The practice does not get involved with divorce/custodial specifics with regard to percentage of financial obligation.

No-Fault/ Workers Compensation

Office and hospital visits for patients are billed to the NF/WC carrier provided a primary insurance card with proper referral (if necessary) and ***Assignment of Benefits*** form (NF Only) is on file.

Refunds

The following criteria must be met prior to the practice issuing a refund. The patient has not been treated by the practice for 60 days, there are no outstanding insurance claims on the patient's account, and there are no outstanding patient balances on the account.
Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

_____ Patient initials to indicate copy received.