Financial Policy for The Foot Center, Inc.

1) As a courtesy, we will bill your insurance for all office visits. *Please remember*, your insurance coverage is a contract between you and your insurance company, and not a substitute for payment. The patient is responsible for any portion of services not covered by your insurance due to deductibles, coinsurance, or copayments on the day of service. This includes all office visits, procedures, injections, and medical devices. Insurance copayments are due when you arrive for your appointment. If you are unable to pay your copay when you arrive for your appointment, you may be asked to reschedule your appointment unless other arrangements have been made with the Office Manager or approval has been given by the Doctor. Under special circumstances, payment plan arrangements can be made. These arrangements are made with the Office Manager prior to you being seen. Our office may set this up for you as a courtesy depending on the circumstance. You will be sent a monthly statement. However, it is your responsibility to know your monthly due date, which will be determined at the time your payment arrangement is contracted. After one missed payment, your arrangement will be voided and the account will be sent to an outside agency for collections.

2) OUTSTANDING BALANCES: Once your claim(s) are filed with your insurance company and payment is received or denied, you will receive a statement informing you of the balance you are responsible for paying. You must pay this balance within 30 days to avoid any penalties. We urge you to keep your account current to avoid any misunderstandings with our office. Account balances past due over 60 days will receive a late fee of $25 and a monthly finance fee of 2% of the total outstanding balance. All account balances past due over 120 days will be sent to an outside agency for collections. <u>At that point, the account is out of our hands</u>. If you need to make special payment arrangements, it is your responsibility to contact The Foot Center before your account is sent to collections. Accounts sent to an outside collections agency/attorney will be assessed 33% of the total balance plus any additional cost, court, or legal fees that may occur as a result of your delinquency. If your account is sent to collections, you may also run a risk of being discharged from the practice and be required to transfer your care to another provider. You will be responsible for all incurred collections fees and/or attorney's fees as well as costs associated with these services.

3) MISSED APPOINTMENTS: We ask that you let us know about cancellations or rescheduling at least 24 hours in advance. If you miss your appointment without contacting the office to cancel or reschedule, you will be a charged a No-Show fee of $50 for the missed appointment. Habitual missed appointments are grounds for dismissal from the practice.

4) There is a $35 charge for all returned checks. You will be responsible for paying this charge.

5) HMO or PPO claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/pre-certification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be received by our office prior to seeing the Doctor.

<u>ASSIGNMENT OF BENEFITS</u>

I, the undersigned, do hereby certify that I (or my responsible party) have insurance coverage with _____ and do assign directly to The Foot Center, Inc. all insurance benefits, payable to me for the services rendered. I also understand that I am responsible for payment of any and all deductibles, coinsurance, copayments, and/or for any other non-covered services. If my account becomes delinquent, and is forwarded to a collections agency or an attorney, I understand I also am responsible for any and all fees incurred. I hereby authorize The Foot Center, Inc. to release all information necessary to secure payment of benefits. I authorize release of medical information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Signature: _____

Printed Name: _____ **Date:** _____