Foot First Podiatry

Patient Financial Policy

Your understanding of our financial policies is an important aspect of your care and treatment. If you hve any questions, please discuss them with our front office staff or supervisor.

> As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

> Unless orther arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. VISA, MasterCard, Discover, cash or check are accepted.

> Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable time, we will have to look to you for payment.

> We have made prior arrangements with certain insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

> All health plans are not the same and do not cover the same services. In the event your health plan determines a service "not covered," you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services, however you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

> **You must inform the office of all insurance changes. In the event the office is not informed, you will be responsible for the denied charges.**

> 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.

> There is a service fee of $25.00 for all returned checks.

Signature of Patient/Responsible Party:_____

Printed Name of Patient/Responsible Party:_____Date_____