CLEAR FORM

PRINT FORM

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Foot & Ankle Reconstructive Surgery
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FINANCIAL POLICY

Thank you for choosing us as your podiatric care provider. Our main concern is that you receive the proper and optimal treatment needed to restore or maintain your health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask.

We ask that all patients read and sign our Financial Policy as well as complete Patient Registration Form prior to seeing the doctor.

Payment for medical services is due at the time services are rendered. We accept cash credit card or checks for payment.

1. Your insurance policy is a contract between you, your employer and insurance company. We are **NOT** a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts. **Some insurance companies arbitrarily select certain services they will not pay for such as and not limited to supplies or injectable medications. You will be billed for these items if not paid.** _____ Please initial.
3. *Fees for services, with unpaid deductibles and co-payments are due at the time of visit.*
4. If the insurance company does not pay the balance in full within 30 days of billing, we ask that you contact the carrier to help speed up the process. If the insurance company does not pay within 45 days of billing, we require you to pay the balance due in cash or by check. If the insurance company pays, you will receive a full refund. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialists providers which are assigned or not assigned to my insurance policy rule. _____ Please initial
5. Returned checks and balances older than 45 days will be subject to additional collection fees and interest charge of 1½ % per month. _____ Please initial.

Please cancel at least 24 hours in advance if you are unable to keep your scheduled appointment. You may be charged for missed appointments at the rate of a normal visit. _____ Please initial.

We understand that temporary financial problems may affect timely payment of your account. However, we encourage you to communicate any such problems to this office.

Thank you for choosing us as your podiatric care provider. We appreciate your trust as well as the opportunity to serve you.

Patient's Signature _____ **Date** _____