ASSOCIATED PODIATRISTS, LLP
FINANCIAL POLICY

We are glad you have chosen our office to help you in your health care. The doctors and staff strive to prescribe the best up to date treatments possible.

Full payment is expected on the day medical services are provided unless you have health insurance coverage with a plan that we have a written agreement. Our financial policy offers you a number of payment options such as: cash, checks, and Visa and MasterCard. Patients with insurance must pay, when applicable: **Deductible-**an amount you must pay first out of your own pocket each year before insurance will pay for any services. **Co-payment-** an amount you must pay upon each visit to a doctor that is due at the time of service; **Co-insurance**- an amount which usually is a percentage of the fee that your insurance company will not pay. Deductibles, co-payment, and co-insurance are patient responsibility. On treatments that involve items that are non-covered by insurance, or custom order items, you will be required to pay 50% down at the time of visit, and the remaining balance when the product is dispensed. Orthotics require a deposit of $100.00 at the time of casting, and miscellaneous supplies are to be paid upon dispense.

We will need to make a copy of the front and back of your insurance card at your initial visit. Existing patients are to inform us of any changes in coverage that may have occurred since your last visit and provide us with insurance card copies at that time. If you have two or more insurance policies, it is your responsibility to inform us which policy is **Primary** (first) coverage, which policy is **Secondary** (second) coverage, and which policy is **Tertiary** (third) coverage. With each policy we will require the name, date of birth, address, phone number, and employer of the member who carries the policy.

Billing Statement: If you have a balance on your account, you will be sent a monthly billing statement. We do not send invoices but rather billing statements in the middle of each month.

Payments: Unless other arrangements are approved by us in writing, the balance on your billing statement is due and payable by the last business day of the month the billing statement is issued.

Late Fee Notice: A late fee of $10.00 will be imposed monthly on each patient account that is over ninety (90) days past-due. As defined in the heading of Payments above, only other payment arrangements in writing by us will deter imposing the $10.00 Late Fee.

Charges to Account: We have the right to cancel your privilege to make charges against your account at any time. If the patient's account is in a past due status, services must be paid in full prior to any services being rendered. Charges for services will continue to be paid in advance until the past due balance is paid in full by guaranteed payment methods, such as, Cash, Cashier's Check, or Debit Card.

Past Due Account Balances: If your account becomes past due, we may refer the overdue balance to a collection agency or to an attorney. If we have to refer your account to a collection agency, your account will be assessed a collection fee, not to exceed 29% of the past due principal balance. By initialing below, I acknowledge and agree to pay all collection costs, attorney fees, and all court costs. _____ ***Initials***

No Show Fee: A no show fee of $50.00 will be added to your account after 3 consecutively missed appointments. We require you to provide 24 hour notice of cancellation in order to waive the No Show Fee.

Returned Checks: A $35.00 fee will be charged for any checks returned by the bank.

I acknowledge that I have read and agree with Page 1 of this Financial Policy. _____ ***Initials***

Preferred Provider Agreement Insurances: If we are Preferred Providers with your insurance company, we must follow our signed agreement. If you have a co-payment or deductible, you must pay that at the time of service. It is the insurance company's requirement to make the final determination of your eligibility. Some insurance plans require a referral and/or preauthorization from your primary care physician. You are responsible for obtaining the referral and/or preauthorization prior to your appointment or full payment will be expected for the medical services rendered.

Non-Preferred Provider Agreement Insurances: If we are not Preferred Providers with your insurance company, we will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility/coverage. By signing this Policy, you acknowledge and agree to pay any portion of the charges not covered by insurance. Failure to obtain the necessary referral and/or preauthorization is your responsibility prior to your appointment. Failure to obtain the necessary referral and/or preauthorization may result in lower payment from the insurance company, and/or denial of charges. Payment of these denied services will be expected to be paid in full.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Marital Separation: If a couple is separated, but remain legally married, both parties are equally financially liable. If a minor child is the patient, both parties are equally financially liable.

Divorce: In case of divorce, the party, or parties responsible for charges incurred on the account prior to the divorce remains responsible for the account. If a minor child is treated, either pre or post divorce, both parents are jointly and severally responsible for any balances due.

Transferring Records: You will need to provide a request in writing, if you want to have copies of your records sent to another doctor or organization. The amount charged per page is $.25. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. X-ray copies are available to be transferred to another physician. Copies for x-rays are $10.00 per sheet. We request that you please provide at least 3 days notice, prior to needing copies of your records.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, payment of the bill remains the patient's responsibility. Even if a personal injury claim or lawsuit is pending. See the paragraph that refers to Non-Preferred Provider Insurances above.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

Patient Spouse/Parent/Guarantor Signature: _____ Date: _____

Printed Spouse/Parent/Guarantor Name: _____

By signing this document I acknowledge and agree to this entire Financial Policy.

Please feel free to ask any questions regarding your insurance and treatment in our office and we will do our best to assist you.

Thank You.

ASSOCIATED PODIATRISTS, LLP