Our Financial Policy

We try to provide the highest quality of care to our patients while being considerate of the cost of the care. To help us achieve this and to minimize our administrative cost, we ask that you pay your bill at the time of your visit.

Your Insurance

We will bill those plans with which we have signed contract. You will be responsible for all co-pay and deductible amounts at the time of your visit. We will gladly bill your insurance if you are on a non-contracted plan. You are responsible, however, for paying the entire bill at the time of service. You will then receive reimbursement directly from your insurance company.

- I fully understand that I am financially responsible for all co- pays and deductibles required by my insurance plan, to be paid at the time of my visit.
- **I UNDERSTAND THAT IF CAN NOT KEEP MY APPOINTMENT AND DO NOT GIVE A 24 HOUR NOTICE A CHARGE OF $15.00 WILL BE CHARGED.**
- I understand that I am responsible for any services that my plan determines to be "non-covered".
- I understand that payment is expected at the end of each visit unless other arrangements have been made.
- I understand that if the doctors are not participants in my insurance plan I will be responsible for full payment on the day of service and that the office will file my claims with my insurance plan.
- I understand that medical insurance may not pay my entire bill and that I will receive a bill for the portion of the fees that are my responsibility. I further understand there will be a service charge of $5.00 for past due statements
- I understand that I will be billed $35.00 for all checks that are returned by the bank.
- I understand that the office is not able to verify insurance benefits for every patient. I understand that I am responsible for understanding my plan's benefits and for selecting a physician on the plan.
- I agree to pay all amounts owed and all expenses incurred in collecting any unpaid balance.
- I understand that I will be charged $35 for any letters or paperwork I request from my provider
- I understand that I will be charged $20 for copies of medical records
- I agree to pay $150 deposit for the casting of orthotics at the time the impressions are taken.
- I understand that I will be billed $150 for any scheduled surgery that I do not call and cancel within 72 hours of scheduled surgery
- I authorize release of medical information to my insurance company. (If I do not authorize release, I understand that payment will likely be denied or delayed by my insurance company. In this circumstance, I understand that I will be responsible for my bill).
- I understand that lab and anesthesia services provided in our office are billed independently by the lab and anesthetist.
- I understand that failure to pay said invoice upon mailing of notice of payment constitutes a breach of my payment agreement. In the event of a payment breach, I agree that I will be responsible to the physician for a monthly service charge of 2% of the outstanding balance from the date the service is rendered.
- I further agree to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.
- We offer CARECREDIT that is a revolving health care line of credit. Ask for details

Minor Patients

For all services rendered to minor patients (under the age of 18), we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Referrals

If your insurance plan requires that we obtain a referral for you to seek medical attention with another doctor, you must notify our office seven (7) days in advance of your appointment. Otherwise, we cannot guarantee that you will have this referral. In that event, your visit may be paid "out-of-network" according to the terms of your insurance policy.

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Patient Name Date Signed

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Signature of Patient or Responsible Party