

# J M PODIATRY ASSOCIATES DBA FOOT & ANKLE CENTERS

## FINANCIAL POLICY

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**INSURANCE:** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Due to CUSTOM nature of certain DME (Durable medical equipment such as Arizona brace, Ritchie brace, Orthotic biomechanical devices, custom diabetic insoles), you grant us permission to bill your insurance for only CUSTOM DMEs after 30 days of receipt in our office if you cancel, fail or reschedule your appointment for more than 30 days.

**MEDICARE:** We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service.

**SECONDARY INSURANCE:** Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

**COPAYMENTS AND DEDUCTIBLES:** All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**SELF PAY:** Payment in full is due at the time of service if you do not have health insurance.

**NON-COVERED SERVICES:** Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

**REFERRALS/AUTHORIZATIONS:** We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment will be rescheduled.

**CLAIM SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility. Your insurance benefit is a contract between you and your insurance company.

**PATIENT BILLING:** You will be sent two notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the two notices, your account may be forwarded to collections. If your account becomes delinquent for more than 60 days, you also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not exceeding 50%, court costs, attorney fees and interest fees accrued with the collection of this account. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Credit/Debit Cards, Checks. An additional \$35.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

### Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **FOOT & ANKLE CENTERS**, all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor 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.

I have read the above policy regarding my *financial responsibility* to **FOOT & ANKLE CENTERS** for medical services provided. I agree to pay **FOOT & ANKLE CENTERS** any balance unpaid by my insurance carrier for myself or the below named person.

PRINT Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

### FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

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