

## **FINANCIAL POLICY FOR TOTAL FOOT AND ANKLE CENTER, LLC**

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

**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.

**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 copayments, which are 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 deductibles must be paid in full 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 may mandate that when you visit a specialist such as us, you have a referral from your primary care physician prior to seeking specialty care. Therefore, if a referral is required, you are financially responsible for the services received, unless your referral is presented at the time of the visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit.

**CLAIM SUBMISSION:** As a courtesy service to you, we will submit your insurance claims for services rendered in our office 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, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

**PATIENT BILLING:** You will be sent up to three 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 third and last notice, your account may be forwarded to a Collections Agency. 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, Check, or VISA/Mastercard/Discover. 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, otherwise you will be billed and responsible for the balance.

**FORM COMPLETION:** There is a \$15.00 per form charge for any forms you request that the doctor complete. Before the completed forms will be released to you, the fee must be paid. We cannot guarantee when the forms will be completed, but will notify you when they are ready for you to pick up in our office.

I have read the above policy regarding my *financial responsibility* to Total Foot and Ankle Center, LLC for medical services provided. I agree to pay Total Foot and Ankle Center, LLC any balance unpaid by my insurance carrier for myself or the below named person.

**PRIVACY STATEMENT:** Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

**ASSIGNMENT OF BENEFITS:** I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Total Foot and Ankle Center, LLC 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 understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and/or contact information and acknowledge that I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

PRINT Financially Responsible Party's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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

Date: \_\_\_\_\_