The Foot Group, P.C.

FINANCIAL POLICY

THANK YOU FOR ALLOWING US THE OPPORTUNITY TO PARTICIPATE IN YOUR MEDICAL CARE. WE WOULD LIKE TO ASSIST YOU IN UNDERSTANDING THE FINANCIAL POLICIES OF THIS OFFICE.

AS A COURTESY, WE WILL ASSIST YOU BY FILING ALL PRIMARY INSURANCE FOR YOU. WE ALSO FILE SOME SECONDARY INSURANCE. WE WILL ONLY FILE THE INSURANCE COMPANIES YOU HAVE PROVIDED PROPER PROOF OF TO US. PLEASE BE SURE TO LEAVE A COPY OF ALL OF YOUR INSURANCE INFORMATION WITH THE STAFF. IT IS LEFT TO THE PATIENT TO FULLY UNDERSTAND THEIR INSURANCE POLICY AND BE AWARE THAT YEARLY DEDUCTIBLES FOR ALL PROVISIONS OF YOUR INSURANCE POLICY MUST BE MET BEFORE THEY WILL MAKE PAYMENT FOR THE SERVICES RENDERED. THE PATIENT SHOULD BE AWARE OF AND COMMUNICATE TO THE STAFF ALL PRECERTIFICATIONS REQUIRED FOR SPECIAL SERVICES SUCH AS ORTHOTICS AND SURGICAL SERVICES.

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. IN THE EVENT YOUR INSURANCE DOES NOT PAY WITHIN 30 DAYS OF THE DATE OF FILING, THE ACCOUNT WILL BE FORWARDED TO YOU FOR PAYMENT. CHANGES IN INSURANCE INFORMATION SHOULD BE COMMUNICATED WITH OUR OFFICE AS SOON AS POSSIBLE.

ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND CREDIT CARD PAYMENTS. THERE IS A $29.00 FEE FOR RETURNED CHECKS.

SOME AND PERHAPS ALL OF THE SERVICES PROVIDED MAY BE "NON-COVERED" SERVICES AND NOT CONSIDERED REASONABLE AND NECESSARY UNDER THE MEDICARE PROGRAM AND / OR OTHER INSURANCE PROGRAMS.

WHILE THE FILING OF INSURANCE CLAIMS IS A COURTESY THAT WE EXTEND TO OUR PATIENTS, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

ACCOUNTS OVER **90 DAYS** PAST DUE WILL BE SENT TO A COLLECTION AGENCY **UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE WITH THIS OFFICE**. YOUR FUTURE STATUS WITH THIS OFFICE WILL BE CONSIDERED AT SUCH TIME. YOU WILL ALSO BE RESPONSIBLE FOR PAYING ALL COSTS OF COLLECTIONS INCLUDING ATTORNEY FEES.

THANK YOU FOR COMPLYING WITH OUR FINANCIAL POLICY. IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE INFORMATION OR ANY UNCERTAINTY REGARDING INSURANCE COVERAGE, PLEASE DO NOT HESITATE TO ASK US.

AUTHORIZATION TO RELEASE INFORMATION:
THE UNDERSIGN AUTHORIZES THE MEDICAL PRACTICE TO RELEASE ANY MEDICAL OR OTHER INFORMATION ABOUT THE PATIENT WHICH MAY BE NECESSARY FOR PROPER FILING OF ALL INSURANCE CLAIMS, REVIEW OF SERVICES OR RECEIPT OF BENEFITS.

ASSIGNMENT OF BENEFITS:
THE UNDERSIGN ASSIGNS TO AND AUTHORIZES DIRECT PAYMENT OF BENEFITS TO THE MEDICAL PRACTICE. THE UNDERSIGN ALSO AGREES TO ASSIST IN PROCESSING ALL CLAIMS FOR BENEFITS.

FINANCIAL RESPONSIBILITY:
THE MEDICAL PRACTICE STRIVES TO PROVIDE THE BEST POSSIBLE MEDICAL CARE FOR ITS PATIENTS. WE EXPECT THAT WE WILL BE PAID FOR THE SERVICES RENDERED. THE UNDERSIGN AGREES TO BE TOTALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO THE PATIENT INCLUDING ANY NON-COVERED CHARGES. THE UNDERSIGNED ALSO AGREES TO PAY ALL COSTS OF COLLECTION, INCLUDING ATTORNEY FEES, IF THE UNPAID ACCOUNT IS REFERRED FOR COLLECTION.

THIS INFORMATION IS FURNISHED TO YOU TO MINIMIZE ANY CHANCE OF MISUNDERSTANDING REGARDING OUR SERVICES AND FEES. WE CONSIDER OUR FEES TO BE FAIR AND REASONABLE FOR THE QUALITY CARE PROVIDED AND THE PROFESSIONAL STANDARDS WE MAINTAIN.

SIGNED _____ **DATE** _____

(PATIENT, OR GUARANTOR IF PATIENT IS A MINOR)