FINANCIAL POLICY for The Center for Ankle and Foot Care

Welcome and thank you for choosing The Center for Ankle and Foot Care. We are committed to providing you with the highest quality medical care in an efficient, timely, and effective manner. Please review our financial policy below. If you have any questions, please feel free to discuss them with our staff.

1. **Insurance Coverage:** Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly. We are a specialist office and it is always wise to verify your insurance benefits, co-pays, and deductibles prior to your visit or procedure. We will make a copy of your insurance card and driver's license during your initial visit. Existing patients are to inform us of any changes in insurance coverage or demographics that may have occurred since your previous visit.
2. **Co-Payments:** Most insurance plans have a Co-Payment (co-pay). This is an amount you must pay upon each visit to a doctor. Our policy is to collect your co-payment at the time of service. If you are not prepared to pay the co-payment, the visit will be rescheduled. We accept Cash, Check, Debit Card, Visa, MasterCard and Discover.
3. **Deductibles:** In addition to the co-payment, most plans also have an annual deductible. If you have not met your deductible you will be billed for the anticipated approved insurance amount. Payment is expected at the time of service. In the event there is a balance due from you after your insurance carrier has paid its portion we will bill you. We would appreciate prompt payment of your bill after the first statement. If you do not understand the reason you owe a balance, please do not hesitate to contact our office, and the billing staff will explain the balance to you, and answer any questions you might have. If your account becomes past due, we will refer the overdue balance to an outside collection agency.
4. **Referrals:** If you are enrolled in an HMO, which requires a referral from your Primary Care Physician (PCP), it is your responsibility to make sure our office has a copy. You are responsible to keep track of the visits allowed and the expiration date of your referral. If a referral is not in place, your appointment may be rescheduled or any services received without a referral or proper authorization will be your financial responsibility.
5. **Non-Covered Services:** Your insurance plan may not cover all services and/or supplies provided to you during your treatment. In the event your health plan determines a service or item to be "non-covered", you will be responsible for total charges at time of visit or upon receipt of a statement from our office.
6. **Forms:** There will be a *prepaid* fee of $20 *per form* for completing individual medical forms, disability forms, work restriction forms, FMLA forms, employer forms, AFLAC forms, school forms, etc. Payment is due at the time that you request the forms to be completed. Please allow 7 business days for the completion of these forms.
7. **Returned Checks:** A $35 fee will be charged for any checks returned by the bank.
8. **Custom Orthotics:** An attempt can be made by our office staff to determine insurance coverage for custom orthotics. If at the time of your visit insurance coverage has not been determined you will be responsible for $175 which will be applied to the cost of your orthotics. The balance of the orthotics will be due at the time the orthotics are dispensed. If you're insurance company pays all or a portion of the orthotic cost and this results in an overpayment on your account, a refund will be made to you. Our cash pay price for 1 pair of custom orthotics is $500. When you agree to have a custom orthotics made you are agreeing that you will be financially responsible for the cost of the device regardless of insurance coverage. If your orthotics are not picked up in a reasonable amount of time, we will mail them to you and charge your account accordingly.

Please sign below if you have read, understand and agree to the above eight financial policies of The Center for Ankle and Foot Care. I understand that I am financially responsible for any deductible, co-insurance, co-pay, non-covered service or unmet balance and any other charges my insurance may not cover.

Signature of Patient or Responsible Person: _____

Printed Name: _____ Date: _____