

Financial Policy Of Family Foot and Ankle Centers, PLLC

Payment in full is due at time of service unless prior arrangements have been made.

Office visit co-payments for cur participating HMO/PPO insurances are due at the time of service. If we have to generate a billing statement to collect your co-payment there will be a **minimum billing fee of \$10.00** added for the administrative costs of billing.

If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment **within 60** days, the balance will be due in full from you. If any payment is made subsequently **by** your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office.

HMO/PPO claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/precertification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be presented to our business office before seeing the doctor.

**Please present your insurance** card each time you visit if we participate with your plan to insure proper filing information to submit claims. Otherwise, your visit may not be covered and you will be responsible for payment.

There is a \$50.00 charge for all returned checks.

All unpaid balances are subject to 5% interest or minimum \$10.00 service charge after 90 days.

Please be on time for your appointment. If you need to reschedule your appointment, we require a minimum of 24 hours notice. If you missed the scheduled appointment without notifying our office a \$50.00 charge will be added to your account.

If your account must be forwarded to a collection service and/or an attorney because of non-payment, you will be responsible **for all collection fees** and/or attorney fees charged by these services.

**ASSIGNMENT OF BENEFITS**

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to **Family Foot and Ankle Center PLLC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, any third party as it materially relates to services provided, or requested by physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

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

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_