PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

I PLAN TO MAYKE PAYMENT OF MY MEDCIAL EXPENSES AS FOLLOWS: ☐ CASH ☐ CHECK ☐ CREDIT CARD

As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. We will also keep track of necessary documentation, referrals, and pre-certifications you will need to be treated at our office. However, as our patient, you are ultimately responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied. Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. If you are undergoing a surgical procedure, one third of surgery fees is required prior to surgery. If not covered by insurance, payment is expected in full. It is expected that all fees be paid in full within 60 days of the date of surgery whether you insurance payment has been received or not. Pre-certification of surgical procedures will be done as a courtesy to you; however, it is ultimately your responsibility to notify your insurance carrier prior to any surgical procedure.

Your insurance policy is a contract between you and your insurance company. If your insurance company does not pay the practice within a reasonable period following an office visit, you will be responsible for any unpaid balance. We have made prior arrangements with most insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. “Usual and customary” rates may be different from charges for services rendered. You will be responsible for payment of any differences without regard to insurance determination of usual and customary or similar type coverage by insurance carrier(s). In addition, you agree not to delay on payment due to personal bankruptcy and or attorney advisement to not pay on the account nor any court action including and not limited to worker’s compensation cases or injuries.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

If you are Medicare eligible, a claim will be filed on your behalf for covered services. We will file acclaims for non-covered services upon request. You are responsible for filing a claim to your supplemental insurance company for deductible and / or co-insurance reimbursement unless you are covered by Medicaid or a Medigap insurance carrier, or if surgery is performed. In the event surgery is performed, you will receive a statement once Medicare acknowledges the claim.

The responsibility for payment of services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office. There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee. A re-billing fee of $5.00 will be charged to your account each month for any unpaid balance. All payment are due by the tenth (10th) day of each month. Thank you for you understanding or our Financial Policy.

I authorize treatment of the person named below and agree to pay all fees and charges for me and my family shown by statements promptly upon presentation thereof unless credit arrangements are agreed in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. I fully understand all terms and conditions, and this has been fully explained to my / our satisfaction, and I/we have completely read this financial agreement and authorization for treatment.

AUTHORIZATION AND ASSIGNMENT

I authorize the Foot Specialists of Acadiana to release medical information that may be necessary to request claim reimbursement from insurance companies to process my claim(s). I also authorize claim payments including major medical benefits to be made to the Foot Specialists of Acadiana. I understand that I will be refunded any overpayment. I understand that I am ultimately responsible for payment of my account and if this assignment or claim is rejected, it will be my responsibility to pay any unpaid charges in full.

I authorize the Foot Specialists of Acadiana to secure whatever information regarding any claim to any insurance company doctor he feels necessary in assisting me in reaching its settlement or understanding of certain aspects of its settlement. This authorization and assignment may be revoked by me at any time by a written notice.

I agree a photocopy of this for may be used in lieu of the original.

____ Date: ____/____/____

Signature of Patient/Responsible Party:

Printed Name: ____________________________

____ Date: ____/____/____

Witness:

Printed Name: ____________________________