

Dr. Michael G. Fine, Clarendon Podiatry Center

FINANCIAL POLICY

We Accept Visa, Mastercard, Discover, Checks and Cash

The following is a statement of our FINANCIAL POLICY which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have complete and accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, contract limitations etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service. There will be a \$35.00 charge for returned checks. Any insurance balance over 90 days will become the entire responsibility of the patient. Any patient balance over 30 days will be charged a \$5.00 monthly billing fee. Delinquent accounts will be referred for collection at the discretion of the office manager.

CO-PAYMENTS: Please be prepared to pay all co-payments at the time of service. If you do not know your co-payment you will be charged \$25.00. If your co-payment is less the over payment will be returned to you in a timely manner.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount will be billed to you after your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

ORTHOTICS: Orthotics are a non-covered service by some insurance plans. You will be required to pay half of the orthotics charge at the time of examination and casting. The remainder is due when the orthotics are dispensed.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at time of purchase. We cannot bill for these items. In addition, we contract with outside suppliers to provide some supplies through our office. If any of these supplies are used for your treatment you or your insurance will be billed for these supplies by the outside provider. Dr. Michael Fine has no part in billing for these supplies.

What is your co-payment per visit? \$

What is your annual insurance deductible? \$

How much of the deductible has not been paid? \$

I have read and agree to the terms set forth in the above financial policy. I understand and agree that I am financially responsible for any balance due.

SIGNED _____

DATE _____