OUR FINANCIAL POLICY

Thank you for choosing us as your foot care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE

(This includes your co-pays, deductibles, insurance percentages and assignment of insurance payments.) **There will be a $5.00 charge for re-billing on any patient balance over 30 days delinquent. Any balance that is not paid in full after 30 days will be charged an extra 1.5% interest per month. You will be billed a minimum office charge for any scheduled visit not canceled 24 hours prior to service. Any bill over 90 days from date of service may be sent to collections. You are then responsible for an additional 35% collection fee charge plus any attorney fees. You may be ask to sign a credit cards slip to guarantee medical service payments if we have reason to believe an insurance carrier may not pay for services or if self pay.**

REGARDING INSURANCE

We may accept assignment of insurance benefits however, be aware that the charges, whether your insurance company pays or not, is your responsibility. We cannot bill your insurance unless you give us your insurance information. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. **WE ARE NOT PARTY TO THAT CONTRACT.** If your insurance company has not paid your account in full within 90 days, the balance will automatically become your responsibility. Please be aware that 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 medical insurance.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and verify the accuracy of the information given. I assign insurance benefits directly to Dr. Robert Spalding, if any, otherwise payable to me for services rendered. I will allow verbal/written/faxed reports about my appointments or health records to be left on my answering machine or with a family member. I understand that I am financially responsible for all charges whether or not paid by insurance. I additionally understand Medicare or other insurance may not cover some podiatric services and I will be responsible for any non-covered services. I hereby authorize the doctor to release all necessary information to secure payment of benefits and authorize use of this signature on all insurance submissions. I am aware that if my account goes to collections, I am responsible for a 35% additional collection fee and/or legal fees.

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Authorized Signature *Date*