OUR FINANCIAL POLICY

Thank you for choosing us as your health 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 read and sign prior to any treatment.

All patients must complete our Information packet and produce Insurance Cards to be copied before seeing the doctor.

CUSTOM MADE PRODUCTS (SHOES, INSERTS, ORTHOTICS, ETC.) ARE NON-REFUNDABLE

NON-INSURANCE PATIENTS (SELF PAY):

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS OR CREDIT CARDS
WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

INSURANCE COVERAGE:
Regarding Insurance Plans where we are NOT Providers:

We may accept assignment of insurance benefits after your second visit. However we do require 30% of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and original claim form if required. Your insurance policy is a contract between you and your insurance company. We are not a party to that contact. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan, pay 20% percent of the charges at the time of service or provide a credit card with authorization to bill the account for the balance. If your insurance has not paid your account in 30 days we will, on your behalf file a complaint with the Insurance Commissioner. If after the complaint has been filed, and the account is not paid in full by 45 days (from the date of service), the balance will automatically be transferred to your credit card or the extended payment plan. 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.

Regarding Insurance Plans where we ARE participating providers. All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for the payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS:

Adult patents are responsible for their portion of payment at the time of service depending on Self Pay or Insurance Coverage.

MINOR PATIENTS:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

UNPAID BALANCES:

All accounts with unpaid balances at the end of each month will be charged an interest charge of 18%, and will continue each month until balance is paid in full.

ANY AND ALL RETURNED CHECKS WILL HAVE A $25.00 PROCESSING FEE APPLIED TO THE ACCOUNT.

Thank you for understanding Our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

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Signature of Patient or Responsible Party **Date**