Financial Policy for Complete Foot and Ankle Specialists, LLC.

Thank you for choosing Complete Foot and Ankle Specialists, LLC. to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. However, we encourage you to check with your insurance carrier to confirm our participation. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your health care coverage. If you are not insured by a plan we participate with, full payment is expected at the time of service. We require you bring your insurance card(s) and photo ID with you to each visit. If you do not present your insurance card, you will be responsible for payment in full at the time of the service. You are responsible for keeping the office informed as to any changes in your insurance contract or carrier information. Please be aware that your insurance policy is a contract between you and your insurance carrier. We are pleased to provide the service of submitting claims for our patients; however, we remind you that you are ultimately responsible for payment of any services provided to you.

COPAYMENTS AND DEDUCTIBLES: Most insurance plans require that the insured patient pay a co-payment for office visits and other specified services such as x-rays and injections. Complete Foot and Ankle Specialists, LLC is **required** by the plans we contract with to collect your co-pay and any unmet deductible at the time of your service. Any questions you might have regarding co-payments and deductibles should be directed to your insurance company or your employer's human resources department. **Knowing your insurance benefits is your responsibility**.

MEDICARE: We are a participating Medicare provider. Medicare, as well as any secondary insurance, will be billed for you. Patients are responsible for paying their annual deductible if not previously met. Patients are also responsible for any co-payments. Co-payment is typically 20% of the allowed item or service price.

SECONDARY INSURANCE: Your medical claim will be forwarded to any secondary insurance after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: If you do not have health insurance, full payment for services is due at the time of service.

NON-COVERED SERVICES: Please be aware that some of the services you receive **may not be covered** or be considered reasonable or necessary by Medicare or other insurers. Your insurance has the power to deem some medical services unnecessary for your health. You are responsible for payments of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow all guidelines of your managed health care plan that may mandate a referral from your primary care physician to see a specialist. If your insurance requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your visit with us. If your plan requires a referral, and if you do not have a referral from your primary care physician at the time of the visit, you will be financially responsible for all services due in full upon completion of the visit.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance coverage is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance/deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. If your account is referred to collections, you will be held responsible for the collection processing fee of twenty-three (23%) in addition to your balance. We may contact you via telephone at any telephone number associated with your account, including, wireless telephone numbers, which could result in charges to you. As well as text messages or emails using the email address provided to us. Methods of the contact may include pre-recorded/artificial voice messages and/or the use of automatic dialing device as applicable.

If you have any difficulties resolving your bill, please contact our billing department. We accept the following payment methods: Cash, Check, VISA, MasterCard, Discover, and Care Credit. An additional $35.00 fee will be added to your statement if your check is returned for insufficient funds. In the event your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

CHARGES YOU MAY INCUR: If we are asked to complete additional forms or reports for you, there will be additional charges. Form and report completion fees are collected when the request is made. These fees will **NOT** be billed to your insurance company. Additional charges will be assessed for the following: Disability Forms, FMLA forms, Copies of Medical Records, Returned Checks, Attending Physician Statement, and over-the-counter medical supplies.

DURABLE MEDICAL EQUIPMENT/CUSTOM ORTHOTICS: Durable Medical Equipment (DME) and custom orthotics may not be returned. Deposits are non-refundable, unless covered by insurance.

Missed Appointments: Our office policy is to charge a $50.00 fee for missed appointments. Missed appointments are considered those that are not cancelled at least 24 hours in advance to the scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us serve you by knowing your scheduled appointment date and time. Multiple no shows or cancellations may result in being discharged from the practice.

I have read and agree to abide by the above financial policy and have been given an opportunity to ask questions on any points that I did not understand. I agree to pay Complete Foot and Ankle Specialists, LLC any balance unpaid by my insurance carrier for myself or the below named person.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Complete Foot and Ankle Specialists, LLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non- covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the release of my medical information to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

Patient's name (Printed):_____ **Patient's signature:**_____ **Date:** _____

FINANCIALLY RESPONSIBLE PARTY:

Print Name:_____ **Signature:**_____ **Relationship to Patient:** _____