STATEMENT OF BILLING/CREDIT/NOTICE OF INFORMATION

POLICIES FOR THE BENEFIT OF OUR PATIENTS (Rev: 12/9/2021)

1. MEDICARE:

We accept assignment for our Medicare patients and will bill Medicare for you. Do not submit a claim yourself.

Medicare pays 80% of their allowable fee after you have satisfied your yearly deductible. If you have supplemental insurance we are **required** to provide Medicare with this information. In most cases Medicare will forward your claim directly to your supplemental insurance for you.

MEDICARE DOES NOT PAY FOR ROUTINE FOOT/ NAIL CARE OR ORTHOTICS. They also can limit the number of visits per diagnosis. It is your responsibility to pay for services not covered by Medicare. You are required by Medicare to sign a waiver, when appropriate, indicating that you have been informed that Medicare may not cover certain services and that you accept the financial responsibility yourself.

2. FOR OUR CONTRACTED INSURANCE PLANS:
We accept payment based on insurance company's allowable fee structure and the contract your insurance group has with the carrier. Any allowable balances are the responsibility of the patient and are due in full upon receipt of statement.

It is the patient's responsibility to obtain any necessary referrals. If no referral is received by your appointment date, we will request you either reschedule or pay for your visit.

2nd insurance billed only if you supply us with the necessary information and will be billed only one time.

3. NON-CONTRACTED and/or OUT-OF-NETWORK PLANS: contract between YOU and your carrier, so payment for our
We will do the billing from this office for your Primary Insurance as a courtesy. Please furnish us with a current insurance card. For insurances where payment MUST be made directly to you, we request payment at the time of service. Arrangements may be made for monthly payments of larger balances once your payment history has been established.

We request payment at the time of service for co-insurance/co-pays & deductible. 2nd insurances will be billed upon request as a courtesy.

Please understand, private insurance reimbursement is based on the contract between YOU and your carrier, so payment for our services is YOUR responsibility. We do not accept responsibility for collecting an insurance claim or negotiating a disputed claim, however, we will assist you in the effort as a courtesy.

4. NO INSURANCE / AUTO / OTHER INJURY CLAIMS:
Payment in full is expected at the time of service. In some instances other payment arrangements, such as subrogation (3rd party), may be allowed; however, such arrangements must be made with our office prior to your first visit. A letter from your medical insurance carrier to accept subrogation would be required. In most circumstances, we do not accept 3rd party claims.

5. INSURANCE "SET" CO-PAYMENTS: Co-payments are due at time of service and **it is your responsibility** to know the amount and when they are due.

There will be a $10.00 billing charge for "set" co-payments not paid at time of service, and this alternative will be allowed only one (1) time. Additional requests may result in us asking you to reschedule your appointment.

6. METHODS OF PAYMENT / MONTHLY STATEMENTS: We accept cash, personal checks and ALL major Credit **For any balances, we expect payment in full, upon receipt of statement. If full payment is not made, applicable service charges will apply.**

For larger balances, we may consider reasonable monthly payments or we will request you apply for a 3rd party credit service such as Care Credit. However, this plan **must be** agreed to prior to treatment being rendered.

Monthly statements will include re-billing charges beginning with the second statement.

7. FAILED AND CANCELLED APPOINTMENTS:
Patients who fail to show or cancel their appointments without giving our office at least 24 hours' notice may be charged **$50.00 fee for appointments** and a **$200 fee for EACH surgery that you cancel / reschedule**, **requiring payment PRIOR to rescheduling.**

8. INSURANCE / DISABILITY / MISC FORMS: There will be a minimum ***$15.00*** fee for each form requiring physician completion if not requested or paid by your medical insurance carrier.

9. There will be a charge of *$25.00* for all checks returned due to insufficient funds, and a *$5.00* charge for a declined credit card.

10. HIGH DEDUCTIBLE PLANS: If you have a high deductible ($1000 & over) and have not met that deductible at the time of your visit with us, we will request payment at time of service. We will bill your insurance so they can apply the charges to your deductible.

11. Should my account, or an account for which I am financially responsible, be referred to a collection agency for non-payment, I am aware that I will be responsible for all charges transferred by Ankle & Foot Clinic to the collection agency, including any unpaid balances and re-billing fees. I also agree to be financially responsible for reasonable attorney fees. Non- payment may result in my being reported to a credit bureau.

12. Per HIPAA guidelines, you are not required to provide us with your social security # unless this is used as identification by your medical insurance carrier.

***Please request a copy of our Notice of Privacy Practice for all details regarding the use and disclosure of your private health information ***

I ACKNOWLEGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND HAVE READ (OR HAD THE OPPORTUNITY TO READ) AND UNDERSTAND THE NOTICE.

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. This information provided by me is current, accurate and complete to the best of my knowledge.

I authorize all payments to be made directly to Ankle & Foot Clinic of Everett or my provider on my behalf for any services or supplies furnished by my doctor or Ankle & Foot Clinic of Everett and for my doctor to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies as well as to Medicare in order to determine benefits or the benefits payable for related services, now or in the future.

Patient Name (Please Print) _____ Signature of Person Financially Responsible _____ Date _____

Patient Date of Birth:_____ (Rev: 12/9/2021)