

FINANCIAL POLICY OF THE FOOT AND ANKLE CENTER OF NORTHERN COLORADO, P.C.

Thank you for choosing us as your health care provider. We are committed to the highest standards and excellence in your treatment. 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 request you read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER & AMERICAN EXPRESS

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPANT AS A PROVIDER

A valid insurance card must be presented at time of service. All copays and deductibles are due at the time of treatment before the patient is seen by the doctor. In the event that your insurance coverage changes to a plan where we are not participating as a provider, refer to the paragraph below. Undetermined deductibles are payable within 30 days of the insurance payment unless a payment plan is established and signed by the patient and billing office. We cannot bill your insurance company unless you give us your correct insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Medicaid or Colorado Access patients must have their current card with them. Patients must have a proper referral from their primary care provider (PCP) when indicated by their insurance. Patients without proper insurance ID will need to be rescheduled.

REGARDING CASH PATIENTS (no insurance) OR INSURANCE WE DO NOT PARTICIPATE WITH

There may be some insurance plans we do not participate with. This means we are not required to accept assignment regarding benefits. We require \$135 of the bill to be paid on the initial visit and \$50.00 of the bill to be paid at each time of service. The patient will not be seen until payment is made. The balance is your responsibility whether your insurance company pays or not. Balance is due upon subsequent visits or a written payment agreement must be established with the billing office.

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 payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ORTHOTICS

Patients are required to pay 1/2 of the orthotic charge at time of service and the balance when the orthotics are dispensed. No exceptions will be made unless a payment agreement has been established and signed by the patient and billing office.

SUPPLY ITEMS

Any supply items dispensed to the patient will be handled as self pay only. We do not bill insurance for supplies.

SURGERY PATIENTS

We will verify coverage on surgery procedures for the patient’s convenience. After verification, deductibles and copays and/or a deposit will be collected when patient signs the consent form for surgery papers. Payment arrangements may be made on an individual basis.

MINOR PATIENTS

The adults (or guardians) accompanying a minor patient 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, such as Visa, MasterCard, or payment by cash or check at time of service.

CANCELLED OR MISSED APPOINTMENTS

Please give us a courtesy call if you cannot make your scheduled appointment.

LATE FEES

We reserve the right to charge a late fee in the amount of \$10.00 every 30 days for no payment made on your account within that time frame each month.

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:

X _____ Date _____
Signature of Patient or Responsible Party

X _____ Date _____
Signature of Co-Responsible Party