DC Foot and Ankle
www.dcfootandankle.com

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FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

I authorize payment of medical benefits to Drs. Sibel, Firestone and Schwartz, for all services provided. As our patient, you are responsible for making sure that the bill is paid in full. All charges are your responsibility and not the insurance company's. We must emphasize, as your podiatric medical care provider, our relationship is with you and not your insurance company. Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. The filing of a medical insurance claim is an expensive process that we extend to you at no charge. However, **we do ask that you pay all co-pays, deductibles and non-covered charges the day of your service**. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

If your co-payment is not paid at the time services are rendered, you will be responsible for an additional **$10.00 billing fee**.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be non-covered, applied to your deductible, or part of your coinsurance**,** you will have (30) days to pay the balance in full. If you fail to pay in a timely manner, you understand that your account will be subject to collection proceedings. **All fees including collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office**.

If payment is not received in the (30) days required and additional statements must be sent to collect the balance, a **$10.00 rebilling fee** will be added to each statement until the balance is paid in full.

I understand that it is my responsibility to provide the office with my current insurance card at the time services are rendered to me. If I cannot provide my current insurance card, my appointment will be rescheduled or I will chose to pay for the services out of my pocket.

I understand that if I provide incorrect or expired insurance information, I will assume full financial responsibility for all charges incurred.

I understand that my account may be charged a **$60.00 cancellation fee**, if I do not call to cancel my appointment at least (24) hours before my scheduled appointment time. This amount must be paid prior to any future visits with our office.

I understand that my account may be charged a **$200.00 cancellation fee**, if I do not cancel my scheduled surgery at least (72) hours before my scheduled surgery day. This amount must be paid prior to any future visits with our office.

For your convenience, our office accepts all major credit cards, checks, money orders and cash. You agree to be responsible for a **$30.00 service fee for all returned checks**.

Drs. Sibel, Firestone and Schwartz reserve the rights to charge for expanded services such as Telephone consultations, E-mail consultations and copies of medical records. (The receptionist can provide a copy of fees for expanded services by your request).
By signing this document, I acknowledge that I have read it, understand it and agree to the above stated terms and conditions.

_____ _____

Signature of patient or legal guardian Date

_____

Please print name