

Financial Policy For Foot & Ankle Specs. of Del. Co., LLC.

- If the office does not participate with or except assignment from your health insurance, payment in full will be due at the time of service unless prior arrangements have been made.
- Office visit co-payments for our participating HMO/PPO insurances are due at the time of service. If we have to generate a billing statement to collect your co-payment there will be a minimum billing fee of \$5.00 added for the administrative costs of billing.
- If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office.
- HMO/PPO claim denials due to no referral or authorization are the patient's responsibility. Our office staff will notify and assist you in referral/precertification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals must be presented to our receptionists before seeing the doctor.
- Please notify our receptionists or billing office if there is any change in your insurance, otherwise your visit may not be covered and you will be responsible for payment.
- There is a \$25.00 charge for all returned checks.
- All unpaid balances are subject to 1.5% interest or minimum \$5.00 service charge after 90 days
- If your account must be forwarded to a collection service and/or an attorney because of non-payment, you will be responsible for all collection fees and/or attorney fees charged by these services.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage that will pay for my medical care and assign directly to **Foot & Ankle Specialists of Delaware County, LLC., Dr. Samuel and Associates**. 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 RELEASE OF 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.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Patient or Guardian: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature