

College Park Foot Center's Financial Policy

We are glad you have chosen our office to help you in your health care. The doctors and staff strive to prescribe the best up to date treatments possible. Full payment is expected on the day medical services are provided unless you have health insurance coverage with a plan that we have a written agreement. Our financial policy offers you a number of payment options, which are cash, checks, and credit cards (Visa, Master Card). Patients with insurance must pay the following when applicable.

DEDUCTIBLE - an amount you must pay first out of your own pocket each year until met and before insurance will pay for any services rendered (Medicare is \$135 private insurance has anywhere from \$200 to \$5,000) is due at time of service when allowed by your insurance policy.

COPAYMENT - an amount you must pay before each visit to a doctor is due at time of service.

COINSURANCE - an amount which is usually a percentage of the fee that your insurance company will not pay.

Deductibles, co-payment and co-insurance are your responsibility to pay by law. On treatment that involves laboratory fees (custom orthotics, diabetic shoes, etc.) that is not covered by insurance or the deductible have not been met you must pay 50% down and 50% when the product is dispensed. We will need to make a copy of the front and back of your insurance card at your initial visit. We expect you to inform us of any change in coverage that may occur and provide us with insurance card to copy at that time. If you have two or more insurance policies, it is your responsibility to inform us which policy is **Primary** (first) coverage, which policy is **Secondary** (second) coverage, and which policy is **Tertiary** (third) coverage. With each policy we will require the name, date of birth, address, phone number, and employer of the member who carries the policy.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurance: if we are contracted with your insurance company, we must follow our contracted guidelines and their requirements. If you have a co-payment or deductible, you must pay that at the time of service. The insurance company makes the final determination of your eligibility. Some insurance plans require a referral and/or preauthorization from your primary care physician. You are responsible for obtaining the referral and/or preauthorization prior to your appointment or full payment will be expected for the medical services rendered.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary

insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, the insurance company makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. It is your responsibility to obtain the referral and/or preauthorization prior to your appointment. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and full payment will be expected for the medical services rendered.

Required Payments: Any co-payments or deductible required by an insurance company must be paid at time of service. Because this is an insurance requirement, we cannot bill you for these.

Return Checks: There is a fee (currently \$35.00) for any checks returned by the bank for any reason.

Past Due Balances: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorneys' fees, which we incur plus all court costs.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you are past due, status is reported to a credit-reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to your personal injury.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent care.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions herein and the agreement will be in full force and effect. I have read the above financial policy and understand it fully.

Print Patient's name:

Print Responsible Party:

(if not the patient)

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee benefits coverage with _____ and hereby assign and convey directly to Dr. Malinsky's office medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and of outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage and any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian

DATE

Relationship to patient