

## INSURANCE AND PAYMENT POLICIES

In an effort to better serve you, we would like to inform you in advance of your visit, policies related to your care.

- 1.) **Insurance-** We participate and accept assignment in most insurance plans, including Medicare. You are responsible for all co-payment, co-insurance, and/or deductibles per your insurance coverage. While we do bill your insurance company, you are responsible for any unpaid balances. If you are not insured by a plan we do business with, payment is expected in full at each visit. If you are insured but don't have an up-to-date insurance card, payment in full may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2.) **Co-payment and deductibles-** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or unpaid balances at each visit.
- 3.) **Referrals-** Patients with insurance policies that require referrals from your PCP to see a specialist are responsible for obtaining their referrals prior to the scheduled appointment. Patients who do not have a valid referral by the registration time of the appointment will be required to sign a wavier making you responsible for the services in full.
- 4.) **Non-covered services-** Please be aware that some- and perhaps all- of the services you receive may be non-covered or not considered medically necessary. Including, but not limited to, Supplies and/or testing, nail trimming, whirlpools, orthotics pre-fabricated insoles, post-op shoes, etc. You must pay for these services in full at the time of your visit unless other arrangements are made with office manager.
- 5.) **Proof of insurance-** All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license or valid photo ID and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balances of an unpaid claim.
- 6.) **Claim submission-** We will submit your insurance claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your Insurance benefit is a contract between you and your insurance company; we are not party to the contract.
- 7.) **Coverage changes-** If your insurance changes, you are required to notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- 8.) **Non-payment/past due accounts-** If your account is over 90 days past due a monthly interest charge of 1.5% will be added to the unpaid balance (18% annual percentage rate). Partial payments are only accepted if negotiated in advance with the office manager. We charge a \$20.00 service charge for all returned checks plus the original check amount. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If your account is referred to a collection agency, the patient or the responsible party agrees to reimburse About Feet, LTD and/or the chosen collection agency for all collection expenses, court costs, plus a reasonable attorney fee equal to 33 1/3 % of the amount owed on the account in addition to any balances owed on the account itself.
- 9.) **Missed appointments-** In an effort to meet the demands for patient appointments, our policy is to charge a \$50.00 fee for missed appointments not canceled within 24 hours prior to the scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- 10.) **Form completion-** There will be a \$15.00 charge for items which the physician and/or staff are requested to complete including but not limited to the following items:
  - a. Letter of Medical Necessity
  - b. Prior Authorization of medications through an insurance company
  - c. Disability Forms up to 2 pages, \$25.00 for 3+ pages
  - d. Family Medical Leave Forms
- 11.) **Medical Benefit-** Any and all health benefits to which you are entitled to under any policy of insurance, to the extent permitted by law, payment of those benefits go directly to About Feet, LTD and/or Brian R. Wright, DPM.

**I, the undersigned, have read, understand and agree to the policies described above, and understand that About Feet, LTD and/or Brian R. Wright, DPM will render services in consideration of and reliance on my authority to agree and my agreement to abide by the terms/guidelines above. I further understand and agree that a photocopy or facsimile of this agreement shall be as valid as the original and that any attempted modification of the above terms shall be void and without effort.**

\_\_\_\_\_  
Patient's Signature (or legal guardian)

\_\_\_\_\_  
Date

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### Notice of Privacy Policies Written Acknowledgement Form

In compliance with federal privacy law and regulations, all patients must, on their initial date of registration and thereafter upon request, sign and date this Written Acknowledgement Form.

We do not attach a copy of our privacy policies to this registration form. If you would like a copy, we are happy to provide one at anytime you request.

I HEREBY ACKNOWLEDGE THAT I UNDERSTAND I CAN REQUEST A COPY, AT ANY TIME, OF OUR PRIVACY POLICIES AND I FULLY AGREE TO THE TERMS OF THE POLICY.

\_\_\_\_\_  
Patient's Signature (or legal guardian)

\_\_\_\_\_  
Date