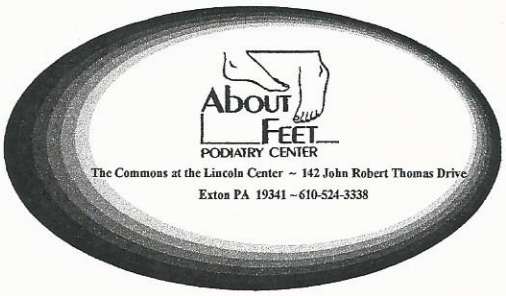


FINANCIAL POLICY For About Feet Podiatry Center

FINANCIAL POLICY :

Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. **ULTIMATELY, YOU AND ONLY YOU ARE RESPONSIBLE FOR UNDERSTANDING THE SPECIFICS OF YOUR INSURANCE PLAN.** You bear full financial responsibility for the services rendered and products provided by About Feet Podiatry Center and agree to pay at the time of service.

Payments that you are responsible for include but are not limited to any and all copayments, coinsurances and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Please note that copayments for office visits are usually higher for specialists (like podiatrists) verses primary-care physicians. So check with your insurance carrier to determine if you have a higher copayment for specialists. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coinsurances and deductibles than your office visit. Again, check with your insurance carrier to determine how your benefits apply.

Though About Feet Podiatry Center will attempt to determine and collect your payment responsibility at the time of service, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company within 30 days of being notified by either your insurance company or About Feet Podiatry Center. Our charges may be estimated based on each insurance company's fee schedule. After your insurance processes the claim and if a balance is due you will receive a statement. If a refund is due, we will be happy to mail it to you.

KEEPING YOUR ACCOUNT UP-TO-DATE:

It is your responsibility to inform us of any changes in your insurance, telephone numbers and address. Please have your insurance cards available at all office visits. Insurance companies give us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

DELINQUENT ACCOUNTS:

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed. In the event your account is turned over to a collection agency, you agree to pay all reasonable collection costs.

RETURN CHECKS:

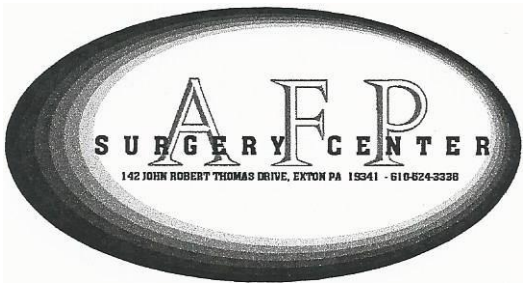
There will be a $25.00 charge for all returned or cancelled checks. Personal checks will not be accepted for future payments. The office will accept payment in the form of a cashier's check, money order, cash or credit card (VISA, MasterCard, Discover).

ALL COPAYMENTS, COINSURANCES, DEDUCTIBLES, FEES AND OUTSTANDING BALANCES MUST BE SETTLED BEFORE SEEING THE PHYSICIAN. WE RESERVE THE RIGHT TO IMMEDIATELY CANCEL YOUR CARE FOR CONDUCT, NON-COOPERATION OR NON PAYMENT.

Your signature represents your consent to treatment necessary for the patient names, your acknowledgement of full financial responsibility and your understanding and acceptance of your policies detailed above.

_____	_____	_____
(Signature)	**(Print Name)**	**(Date)**

Revised: February 24, 2015



FINANCIAL POLICY for AFP Surgery Center

AFP Surgery Center is a physician owned facility (Edward J. Piskorski, DPM & Jason S. Hearn, DPM). I am aware that I have the right to receive care at any in-network/out-of-network facility of my choosing.

FINANCIAL POLICY:

Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. ULTIMATELY, YOU AND ONLY YOU ARE Responsible FOR UNDERSTANDING THE SPECIFICS OF YOUR INSURANCE PIAN. You bear full financial responsibility for the services rendered and products provided by AFP SURGERY CENTER and agree to pay at the time of service.

Payments that you are responsible for include but are not limited to any and all copayments, coinsurances, and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Please note that copayments for office visits are usually higher for specialists (like podiatrists) verses primary-care physicians. So, check with your insurance carrier to determine if you have a higher copayment for specialists. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coinsurances, and deductibles than your office visit. Again, check with your insurance carrier to determine how your benefits apply.

Though AFP SURGERY CENTER will attempt to determine and collect your payment responsibility at the time of service, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company within 30 days of being notified by either your insurance company or AFP SURGERY CENTER. Our charges may be estimated based on each insurance company's fee schedule. After your insurance processes the claim and if a balance is due you will receive a statement. If a refund is due, we will be happy to mail it to you.

KEEPING YOUR ACCOUNT UP-TO-DATE:

It is your responsibility to inform us of any changes in your insurance, telephone numbers and address. Please have your insurance cards available at all office visits. Insurance companies give us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

DELINQUENT ACCOUNTS:

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed. In the event your account is turned over to a collection agency, you agree to pay all reasonable collection costs.

RETURN CHECKS:

There will be a $25.00 charge for all returned or cancelled checks. Personal checks will not be accepted for future payments. The office will accept payment in the form of a cashier's check, money order, cash, or credit card (VISA, MasterCard, Discover).

ALL COPAYMENTS, COINSURANCES, DEDUCTIBLES, FEES, AND OUTSTANDING BALANCES MUST BE SETTLED BEFORE SEEING THE PHYSICIAN. WE RESERVE THE RIGHT TO IMMEDIATELY CANCEL YOUR CARE FOR CONDUCT, NON-COOPERATION, OR NON-PAYMENT.

Your signature represents your consent to treatment necessary for the patient names, your acknowledgement of full financial responsibility and your understanding and acceptance of your policies detailed above.

_____ _____ _____

(Signature) (Print Name) (Date)

Revised: July 10, 2018