Center for Podiatric Medicine Financial Policy

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The bill for services rendered is **your responsibility**. Options for payment include private health insurance, self pay, and third party injury claim such as worker's compensation or personal injury. For your convenience cash, checks, and Visa or Mastercard is accepted with proof of identification required. There will be a $25.00 service charge for all returned checks. I understand that there will be a $25.00 charge for a cancelled appointment without 24 hours notice. Patients under the age of 18 **must** be accompanied by a parent to receive treatment.

All office visit co-pays are due prior to services being rendered. Your insurance will be billed, and the remaining balance is due upon receipt of the billing statement unless prior arrangements are made. You are required to present a current photo identification card and health insurance card on the first visit. You will be expected to provide the Center for Podiatric Medicine with any information required to get your insurance claims paid.

All self pay charges are due at the time the services are rendered unless prior arrangements are made. After 90 days, any unpaid patient responsibility will automatically be turned over for collection unless prior arrangements are made. We offer interest free financing through CareCredit. If you are interested, please ask for more details.

If you have filed a personal injury or worker's claim, you are expected to provide the Center for Podiatric Medicine with all attorneys and claim information necessary to submit your claims. In the case of worker's compensation, please report the injury to your employer immediately. Please provide a copy of the employer's first report of injury form.

It is required that you provide us with the information for an active credit card to be kept on file, and understand **it is your responsibility to notify us of any changes pertaining to the card on file**. After your services have been considered by your insurance, you will receive one statement, and the balance is due upon receipt. **If payment is not received by the next billing cycle, the credit card on file will be charged the full amount due unless prior arrangements are made with office.**

Circle One: Visa MasterCard Discover American Express *Please present card for temporary copy to be made*

Card Holder: _____ Last 4 digits of Credit Card #:_____Exp Date:_____CVC:_____

Credit Card Statement Address:

_____

***If you do not wish to give us credit card information to keep on file, you MUST pay for visit in full at the time services are rendered.**

I understand that when providing my credit card information above that I agree that the Center for Podiatric Medicine has my permission to charge this card for any unpaid balances that are outstanding for over 30 days. _____ Initials

_____I do not have insurance. I will pay cash. _____Please bill my insurance: (You must provide a copy of the insurance card)

I authorize the release of any medical information to process my insurance claim. I authorize payment of medical benefits directly to the Center for Podiatric Medicine. I understand that if I receive a check from my insurance company for services provided by the Center for Podiatric Medicine, I am responsible for paying you immediately.

I understand and agree that, regardless of my insurance statue, I am responsible for the balance on my account for services rendered. I have read and understand the above financial policy.

Patient Name (Print) _____ Patient Signature: _____Date: _____

Parent/Guardian Signature: _____ Date _____