LANDMARK FOOT & ANKLE CENTER, P.C.

www.landmarkfootandankle.com

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OFFICE POLICY

We would like to welcome you to our office. We strive to provide top quality care in a comfortable atmosphere. We submit claims to your primary, secondary and tertiary insurances. We have found, however, that few insurance plans cover the entire cost involved in your visit(s). **Your policy is between you and your insurance company and it is important that you understand its provisions**. **We cannot guarantee payment of your claims or accept responsibility for negotiating your claim. At this time, we are not accepting state issued health plans from any new patients (e.g. Medicaid, Anthem Healthkeepers Plus, Famis, Amerigroup, (Aetna Leap plans, only Dr Kim), Community Care Plans, etc).**

Co-payments, Deductibles, and Coinsurance are due at the time of your visit; if you do not pay on the date of service an administration fee of $10 will be added. Please note that you will be required to pay the bill in full if you are a ***SELF-PAY*** patient. We accept cash, checks, all major credit cards and money orders for payments.

If your insurance company requires a referral to be seen by Landmark Foot and Ankle Center, you are responsible for providing this to us the day of your appointment. **If you do not have a valid referral you will need to reschedule your appointment.**

It is the responsibility of the patient to inform us of ANY address changes or insurance changes. *(Note: If your insurance changes and we need to re-bill any claims out under your new policy you will be charged a $10 fee).*

At the beginning of each month, a billing statement will be sent to you, informing you of your account status. Any returned checks will incur a fee of $35.00 plus any bank fees associated with the returned check. **Any account overdue after 90 days will be turned over to collections**. *Any attorney fees, court costs, and all fees involved with the collection process are the sole responsibility of the patient. Be aware that 33 1/3% will automatically be assessed at the time the account is sent to collections.*

It is important that you cancel any office appointment at least 24 hrs in advance, so that we can utilize that appointment time for emergencies if need be. If you fail to cancel within 24 hrs or you do not show up to your appointment, you will be charged a fee of $35.00. If you are scheduled for surgery and cancel within seven business days, you will be charged $100.00. If you do not show up for any scheduled surgery, you will be charged $250.00. This charge is not reimbursable by your insurance company and is your sole responsibility.

Due to increasing administrative and personnel costs, we will be charging for the following: ***Medical records***: 1-20 pages $20.00; $1.00 each additional page, ***X-Rays***: $20.00 per set of x-rays, ***Disability, Work or Medical forms***: $35.00. Please allow up to **7 business days** for your request to be completed.

I understand that my doctor will explain the risks, benefits, and alternative treatments, before any treatment(s) are rendered. These may include surgical procedure(s), diagnostic test(s) and medical care. I authorize my physician to perform such procedures after we have discussed these, which are advisable in their professional judgment.

I, the patient or representative, authorizes Landmark Foot & Ankle Center, P.C. to apply for benefits on my behalf for covered services rendered by Landmark Foot & Ankle Center, P.C. I request that the payments from my providing insurance company be made directly to Landmark Foot & Ankle Center, P.C. I understand that I am responsible and I agree to promptly pay all charges for medical services at the time services are rendered and accept legal responsibility for any and all charges for myself or the patient, including all costs incurred by our collection attorney. I understand that I am responsible for all professional fees and charges regardless of insurance coverage or any other source of payment.

I certify that the information I have reported, with regard to my insurance coverage, is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above named carrier or myself at any time in writing.

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Signature Relationship to patient Date