FOUR STATES FOOT CLINIC FINANCIAL POLICY

This document provides you with the Financial Policies used by Four States Foot Clinic. Your signature and initials are required on this form in order to be seen in our clinic. If you have any questions or need an explanation, please ask a staff member.

Consent to Pay for Services Rendered: Payment is required for all services at the time the services are rendered. Four States Foot Clinic accepts Medicare, Missouri Medicaid and many commercial insurance plans. If we are a contracted provider (in-network) with your insurance plan, we are required by contract with your insurance company, to collect your co-pay / co-insurance and any unmet deductible at the time of service. For patients with private insurance with whom we do not have a contract with (out-of network), you will be responsible for all services rendered at the time of service. It is your responsibility to contact your insurance company to verify that we are in-network and also to know what your coverage benefits are under your policy. Insurance coverage is not a guarantee of payment by your insurance company. Our office will make every attempt to verify your coverage and obtain the correct information from your insurance company, but we do not guarantee benefits and cannot be held responsible for being misquoted benefits by the insurance representative. If your insurance fails to respond or does not pay promptly, we will forward the balance to you for payment. Should your insurance company make payment to our office, we will promptly refund you any overpayment due to you. We accept most major credit cards for your convenience.

PLEASE READ AND INITIAL THE FOLLOWING SPECIFICS REGARDING OUR PAYMENT AND COLLECTION PROCESS.

_____ I understand I will be responsible for any amount due not covered by my insurance company.
_____ I understand that procedures performed in the office often require a biopsy or culture to be obtained and sent to a Pathologist, and there will be a separate charge for those services.
_____ We refer delinquent accounts to an outside collection agency. If it became necessary to refer your account to the collection agency an administrative service fee of $25 will be assessed to your account. In addition, you will no longer be able to make appointments for yourself or your immediate family members until the balance is paid in full.
_____ I understand if I do not show for an appointment and/or I do not notify Four States Foot Clinic 24 hours before the set appointment, there will be a $75 charge that will be my responsibility and will not be billed to my insurance company.
_____ I understand that a $45 returned check fee will be assessed to my account for any check returned by my financial institution. I also understand that payment of the check and the fee will be due immediately and I will no longer be able to issue a check as payment to the practice.
_____ I have read the above financial policy and agree to meet my financial obligation in accordance with this policy.

_____ _____
Print Patient Name Date of Birth

_____
Print Guardian Name

_____
Signature of Patient or Guardian

_____ _____
Four States Foot Clinic Employee Date