

PATIENT FINANCIAL RESPONSIBILITY

At East Bay Foot Clinic,

We strive to give you the best care. In order to serve this purpose, it is important that you understand the mechanisms of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of your service. Understand that you will be expected to pay your co-payment for each and every date of service.
- You are responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount, and how much of that has been met. You will be responsible for finding out all information about your deductible prior to your appointment in the office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to collection fees shall be your responsibility in addition to the balance due to the office.
- Patients who are 90 days past due to their balance will be sent to collections unless a payment plan has been put into place.
- There is a service fee of \$45.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness of all of our patients and staff, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours notice will result in a fee of \$55.00. You will be asked to pay before you are seen by the doctor.

Effective Date: Once you have signed this document, you agree to all the terms and conditions contained herein. This agreement will be in full force until terminated in writing. I have read the above policy and have had the opportunity to have all my questions answered.

Patient Signature: _____

Date: _____