Thank you for choosing Valley Foot and Ankle as your podiatric physicians. We are committed to the success of your treatment. The following is a statement of our FINANCIAL POLICY. We request that you read and sign this policy prior to any treatment.

To avoid any misunderstanding, please contact our office if you have any questions about our policies.

CREDIT/ DEBIT CARD ON FILE: As of August 1, 2015 we require a credit or debit card on file with our office if we will be billing your insurance company. When you arrive for your appointment we will ask for a credit/debit card to place on file which will be held securely. Once your portion of the bill is determined (following a review of your copay, co-insurance and deductible) we will notify you (via email) that we will be charging your card. Five days later, we will then process and charge your card. A copy of the receipt will be emailed to you. This will allow for us to only swipe your card once per year. Please note: you can cancel your contract at any time.

PAYMENTS FOR SERVICES: Payment for services are due at the time that those services are provided to you and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes: copay amounts, program deductibles, earlier charges that remain unpaid and charges for services that we believe are not covered by or are left over as your responsibility to pay after coverage by insurance. Payments must be paid by cash, check, and or credit/debit card. There will be a $25.00 charge for any returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

UNPAID BALANCES AND AUTOMATIC PAYMENTS: Patient balances are due upon final insurance determination of patient balance and will be charged to your credit or debit card on file. You will receive an email notification that we will be charging your credit or debit card and then a follow-up email with the receipt.

CO-PAYS AND UNPAID BALANCES DUE AT THE TIME OF VISIT: Please be prepared to pay all co-payments and unpaid balances at the time of service. We do not mail statements out for co-payments, so your visit will be rescheduled if you are not prepared to pay the co-payment.

MISSED APPOINTMENTS: We ask for at least 24 hours notice if you are unable to keep an appointment. There will be a minimum fee of $62.00 for not showing up to your appointments. We will not reschedule any patient after two missed appointments, if you do not cancel at least 24 hours in advance or you do not show up.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have *complete* and *accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays**. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc.** Failure to do so may reduce the amount of benefits paid by your insurance and the balance will then become your responsibility to pay.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

BILLING COMMUNICATIONS: We may present charges to you by written statement or email following a visit. If we do this, we expect that each charge will be paid in full by return mail or credit card on file the first time it is presented to you.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. We cannot bill for these items and we do not bill your insurance for these items.

ASSIGNMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles, unpaid balances and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)

I have read and agree to the terms set forth in the above financial policy. I authorize my insurance benefits to be paid directly to the doctor. If I am financially responsible for any balance due, I agree to make all payments for any co-payments, charges due within my current deductible and any unpaid balances from previous visits at the time of my appointment.

Print Name _____

Patient or Guardian Signature _____ **Date** _____