WINDY HILL PODIATRY ASSOCIATES FINANCIAL POLICY

Thank you for choosing us for your foot and ankle care. As a health care provider, our primary responsibility is to you, the patient. We are committed to giving you the best possible care with a successful treatment plan. Please understand that payment of your bill is considered a part of your treatment plan. We feel that it is important that you understand how certain issues are commonly handled in our office, so we ask that you read and sign the following statement of our Financial Policy. Please feel free to ask any questions you might have.

NEW PATIENT INFORMATION FORMS: All patients will need to complete our "New Patient" forms. ***It is your responsibility to inform us of any future changes in address, phone numbers, employment, insurance, or health status.***

PAYMENT OF SERVICES: Payment, including managed care co-pays, is required at the time of the visit unless other arrangements are made *prior* to your being seen by the doctor. We accept cash, local checks, and credit cards (Mastercard, Visa, Discover, and American Express). As a courtesy, we do verify insurance benefits, but we cannot be responsible for incorrect or incomplete information given to us by your insurance company. It is each patient's responsibility to know what their policy covers and its limitations. There is a $20.00 returned check fee for any check returned unpaid by the bank. A 30% collection fee will be added to any balances that have to be turned over to a collection agency or attorney for collection.

MANAGED CARE PLANS: In an effort to accommodate the needs and requests of our patients, we participate with many Managed Care Programs (known as "PPO", "HMO", "EPO", and "POS" plans). While we are pleased to be able to provide this service to you, it is extremely difficult to keep up with all the individual plan requirements. It is important that you know what your policy's guidelines are.

If your plan requires referrals from your primary care physician ("PCP"), it is your responsibility to obtain all referrals and to get the authorizations to us. We are unable to provide treatment until we have authorization. If the insurance company denies your claim due to the lack of a referral, payment of the claim will be your responsibility.

Payment of co-pays and deductibles is expected at the time of the visit. We are responsible for making contractual adjustments, but services which are denied as not being covered by your policy are your responsibility.

MEDICARE: We participate with Medicare. Payment of the $100.00 calendar year deductible and the 20% co-pay are the patient's responsibility, unless they are covered by a supplemental policy. We will need to make a copy of your Medicare card for our files and ask that you sign an additional assignment form required by Medicare. If we expect that a service you need will not be covered by your Medicare plan, we will inform you prior to the service being rendered. If you are on a Managed Care Medicare Program, please let us know so that we can make sure we participate with your plan.

TRADITIONAL OR INDEMNITY INSURANCE: As a courtesy, we will file your insurance claims for your reimbursement. Please remember that the insurance is a contract between you and the insurance company and we are not a party to that contract. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determinations of usual and customary rates.

MEDICAID: We also participate with Medicaid. We will need to see your Medicaid eligibility form at each visit. Some services require a co-pay and payment is expected at the time of the visit. Medicaid has many guidelines and often we must obtain approval prior to providing services. Prior approval can take 10-14 days to obtain.

SURGICAL PATIENTS: Patients scheduled for surgery at The Foot Surgery Center or the hospital will be given a packet of information and we ask that you read through the information provided. We will contact your insurance company regarding benefits and pre-certification. A deposit is required prior to most surgeries and the amount of the deposit is determined by the information obtained from your insurance company. The deposit will be used towards payment of your portion of the surgery fees (deductible and co-pays).

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. With your cooperation and help, you should be able to receive all the benefits offered to you by your insurance program, and we will be able to concentrate on caring for your medical needs.

I have read the Financial Policy stated above and agree to accept responsibility as described. I have read all the information on the forms given to me and have completed the answers. I certify that the information is true and correct to the best of my knowledge and I will notify the office of any changes in this information or my health status.

____________________________________ ________________

Signature (Parent's signature if patient is a minor) Date

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We ask that you please sign the assignment of benefits and authorization to release information below. Even if we are not currently filing insurance for you, there may be a need to do so in the future, or your insurance company may request additional information from us on a claim that you filed for our services. (A photographic copy shall be considered as effective and valid as the original.)

I authorize and request my insurance benefits be paid to Dr. Alan Rothstein/Windy Hill Podiatry Associates, P.C., and I understand that I am responsible for any balances other than managed care contractual adjustments.

____________________________________ ________________

Signature Date

I authorize the release of any information necessary to process an insurance claim.

____________________________________ ________________

Signature Date