

FINANCIAL POLICY

Thank you for choosing University Foot & Ankle Institute as your health care provider. We are pleased to be able to render services in the evaluation and treatment of your condition. Please understand that you will be financially responsible for charges that are not covered by your insurance. If you have any questions regarding your financial account with our office, please contact our billing department during normal business hours, at (310) 828-0011, option 4.

Your clear understanding of our Financial Policy is important to our professional relationship.

- We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered.
- If you do not provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We accept cash, check, or credit card (Visa, MasterCard, or Discover).
- Please notify us immediately if there are any changes to your insurance plan or your coverage.
- Co-payments and Deductibles are an agreement between you and your insurance plan, are your responsibility, and are not something we can negotiate.
- Co-payments are due at the time of service and charges to cover your deductible may be requested to be paid toward if it has not been satisfied.
- Medical records or copies of records can be provided at your request; please allow up to 5 (five) business days for records to be compiled. There may be a nominal fee for record copying.

SELF PAY

We expect full payment at the time of service unless prior arrangements have been made.

MEDICARE

We accept Medicare assignment. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.

HMO/PPO

We are providers for many insurance plans, but are not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you must have a current referral at the time of your visit in order to be seen, and for the visit to be covered under your plan. Without a proper referral, you may be responsible for charges incurred.

If you are a PPO member, you are responsible for co-payments, deductible, and co-insurance. Please confirm with your insurance that we are providers covered under your plan.

WORKERS' COMPENSATION

If you are consulting with us regarding a work-related injury, we require information for both your personal insurance coverage as well as your employer's Workers' Compensation insurance. Prior to being evaluated in our office, we need to have a letter or statement from Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. Your employer's human resources office should be able to assist you with obtaining this information. If payment is not received from these third parties within 90 days, we reserve the right to bill you directly.

HOSPITAL AND SURGERY CENTER CHARGES

In the event that you undergo surgery in a hospital or outpatient surgery center, separate charges will be made by the facility. Your podiatric physician with University Foot & Ankle Institute may be part owner or have financial interest in a surgery center where you will be having surgery.

UCR (USUAL AND CUSTOMARY RATES)

We are committed to provide the best treatments possible for our patients. Our fees for services rendered are usual and customary for our geographic area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check, or credit card. Past due balances may be subject to additional fees.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed in a timely manner, to ensure that payment for services rendered. I understand that I am ultimately responsible for payment of all services.

PATIENT OR GUARDIAN NAME (PLEASE PRINT):

SIGNATURE:

DATE: