Feet First Podiatry

Financial Policy & Patient Responsibility Notice

We consider payment of services to be the responsibility of the patient in the patient-physician relationship.
Therefore, we would like to explain our payment policy and patient responsibility expectations to ensure your understanding and compliance. First and foremost, it is expected that you provide our office with the most up to date information about you (contact info, insurance coverage, etc.) at every single visit. Feet First provides many types of medical services within our practice. There are many insurance companies (each offering several different plans or policies) so we cannot know whether a specific service is covered by a plan or policy. It is impossible for Feet First to know the different group benefits from one employer or individual plan to the next. Our staff will make every effort to assist you in understanding your health benefits, although, WE are not responsible for knowing/informing you what services are covered by your health plan.

For the insurance carriers we do participate with, we will file on your behalf directly for payment. Insurance co-payments and non-covered services are expected to be paid in full at the time of service. Additional amounts may be due later, after we have billed your participating insurance (i.e. coinsurance, deductible, uncovered services).
_____ INITIALS

Consequences for non-payment / defaulting on payment of amount due to Feet First:

.1. Unpaid balance after 70 days will be sent to collections. **_____ INITIALS**

Additional Practice Related Fees:

- ___ "NO SHOWS" = $25.00
- ___ Mailed copies of charts = $30.00
- ___ Picked up copies of charts = $25.00
- ___ Medical leave forms = $25.00 **_____ INITIALS**

By signing below, I acknowledge and understand the financial policy of Feet First. I agree to the terms of payment due and accept all payment terms under this policy. I understand my responsibility as a patient to know and understand my health insurance benefits for services provided and agree to pay all applicable charges which are not paid in full by my insurance.

Signature _____ Date ___/___/____