Morgan Hill Foot and Ankle Center
Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. 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.

· Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. If you have a co- payment we are required by our contract to collect it at the time of your visit. We will accept VISA, MasterCard, American Express, cash or personal check.

· Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

· We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible. We will accept payment based on the insurance company's allowable fee schedule and the contract your group has with that carrier. Any allowable balances are the responsibility of the patient or guarantor and are due in full upon receipt of the statement. If you have a secondary or supplemental insurance you must relay this to us to prevent disruptions in payments.

· If you have insurance coverage with a plan with which we do not have a prior agreement (Out of Network Provider), we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service. If Out of Network status is not identified at the time of service you will be billed for the treatment and your payment is due upon receipt of the statement.

· 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 some specialized 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.

· Durable Medical Equipment (e.g. post operative shoes / night splints / camwalkers) or any supplies dispensed during that visit that habe a dedicated HCPCS code will be billed to your insurance company. If they are deemed not a covered benefit, you are responsible to pay the cost for the goods dispensed in full. Any oral representation we make in good faith to you concerning your insurance is not binding on us and will not in any way or for any reason be considered a modification of this billing notice.

· You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

· For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

· There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

· For large balances we may consider a reasonable monthly payment. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office.

· There is a service fee of $25.00 for all returned checks and missed appointments, not canceled 24 hours before. Your insurance company does not cover thess fee.

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. I authorize all payments to be made directly to my provider on my behalf for any services or supplies furnished by my doctor and for my doctor or his / her representative to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies, as well as Medicare / MediCal, in order to determine benefits payable for related services, now or in the future.

Signature of Patient/Responsible Party: ____

Printed Name of Patient/Responsible Party ____________________________________ Date: ____________

_______ Patient initials to indicate copy received ________Patient initials to indicate copy refused