FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive and may create a financial responsibility on your part.

INSURANCE

We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE

We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE

Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES

All co-payments and deductibles must be paid at the time of service.

SELF-PAY

Payment in full is due at the time of service if you do not have health insurance. For your convenience we accept the **CareCredit** healthcare card.

NON-COVERED SERVICES

Please be aware that some of the services you receive may not be covered by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS

We are required to follow the guidelines of your managed care plan, which mandates that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care, if required. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of the visit. If you do not have a referral from your primary care physician at the time of the visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION

We will submit your claim to your insurance company, however your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Any unpaid balance not covered by your insurance is your responsibility.

PATIENT BILLING

You will be sent three notices regarding your outstanding balance after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third notice, your account will be forwarded to collections. Please notify the billing office if you are unable to pay your bill in full. Payment arrangements may be available. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover/American Express. An additional $25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company sends payment directly to you, it should be forwarded to our office to be applied to your balance. In the event, you do not show up for your appointment, and you failed to call the office to cancel or reschedule, you are defined as a “no-show” and will be billed $50.00.

I have read the above policy regarding my financial responsibility to RNV Podiatry for medical services provided. I agree to pay RNV Podiatry any balance not covered by my insurance.

PRIVACY STATEMENT

Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to it’s terms.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to RNV Podiatry all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor’s office if there is a change in my health insurance information.

Patient’s Name (Print) _____Text_____

Signature _____Date_____