06/22

Advanced Foot & Ankle Associates

616.538.4442

Financial Policy

Thank you for choosing Advanced Foot & Ankle Associates as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask questions. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Insurance: We contract with most insurance plans, including Medicare. Because of this contract, we abide by their regulations and fees. Knowing your insurance benefits is your responsibility. You should be aware of your deductibles and coinsurance. Please contact your insurance company with any questions you may have regarding your coverage. If you are not insured by a plan we participate with, then payment in full is expected at each visit. **If you do not have an up-to-date insurance card, payment is expected in full until we can verify your coverage.**

Out of Pocket Costs: All out of pocket costs must be paid at the time of service. This includes deductibles, copays, coinsurance, and non-covered services. This arrangement is part of your contract with your insurance company. Failure on our part to collect from patients can be considered fraud. **If you are unable to pay your out-of-pocket costs at your appointment, then we will need to reschedule your appointment.**

Non-covered services: Please be aware that some of the services you receive may not be covered or not considered "reasonable or necessary" by your insurance company. You are responsible for payment of non-covered services.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance cards to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

Claims submission: We will submit your claim and assist you in any way we can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Account balances: We accept cash, checks and Visa, MasterCard, Discover and Care Credit. Invoices are sent out monthly and are due upon receipt. ***Partial payments will not be accepted***. You will be responsible for any fees associated with returned checks. After 90 days, if a balance remains unpaid, we may refer your account to small claims court or a collection agency. You will be responsible for all processing fees associated with these actions. If you are placed into collections, a fee of 30% of the balance will be added to your account. At this point we will discharge you from practice and you will be directed to seek care elsewhere.

Missed appointments: Our policy is to charge $55.00 for broken appointments and $100.00 for broken procedure appointments not canceled at least 24 hours prior to the appointment time. These charges will be billed directly to you and must be paid prior to your next appointment. Two missed appointments will result in discharge from our practice. If you are a new patient and you miss your appointment, we will not reschedule you. Please help us to serve you better by keeping your regularly scheduled appointment.

Forms and Documents: We will charge $15.00 and require 7-10 business days to complete each form such as disability forms/ FMLA forms. Copies of x-rays are $10. Per page charge for copies of the medical record will apply depending on the number of pages.

Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines. I have been offered to have a copy of this policy for my files.

_____	_____	_____
Signature of patient or responsible party	Print Name	Date