



FINANCIAL POLICY

Practice Name wants to provide you with excellent healthcare while controlling costs. To do this, we need your help. We ask that you please read our financial policy below.

- Insurance information needs to be updated at every visit. As a courtesy to you we will submit your charges to your insurance for payment. For us to do this accurately and timely, we will need to always have your correct information. Please have both primary and secondary insurance cards ready for review at each visit and inform the receptionist of any new information.
- Martin Foot and Ankle's Medical Assistance Panel is closed. We will not be accepting any new patients with a medical assistance plan as their primary insurance. We will not be submitting any claims to a medical assistance plan if it is your secondary insurance; you will be responsible for any unpaid balances.
- Please provide us with any new address, telephone or employment changes.
- Patients with HMO insurance policies must have a valid referral with them for each visit. It is the patient's responsibility to contact his/her Primary Care Provider for this information. If a valid referral is not present at your scheduled appointment time, we will need to reschedule.
- Copays, coinsurance and deductibles are due at the time services are rendered. Any outstanding balances are also due at this time. We gladly accept cash, checks, bank cards and credit cards (Visa, Discover, MasterCard and American Express). Martin Foot and Ankle also offers CareCredit financing options. We can also keep a credit card on file for your convenience. Payment is required at each visit. If you are unable to pay your copay at the time of visit, you will be charged a \$10.00 re-billing fee and/or possible reschedule of your appointment.
- Online Bill Pay through our Patient Portal is available.
- Practice Name know that sometimes financial problems occur. Payment plans may be made with the billing department directly; however these payments must be made in a timely manner and **paid off within 6 months.**
- Self pay patients, those who do not have insurance will need to pay their entire bill at that appointment, unless payment arrangements have been made ahead of time with the billing department.
- It is your (the patient's) responsibility to notify us if you do not want your visit sent to your insurance company. For that particular service, the payment is required in full at the time of visit.
- The financially responsible party at the time of service will remain liable for all charges until payment is received in full.
- Any bill not paid by the date it is due may be turned over to an outside collection agency. If Practice Name needs to use a collection agency or attorney to collect the unpaid amount, the patient will be responsible for the \$18.00 collections fee and costs.
- Practice Name
- Appointment Policy: A \$45.00 charge will be assessed to the patient/guarantor for the following appointments. A no show is defined as failure to keep your appointment or failure to notify our office 24 hours prior to your appointment. A rescheduled appointment within 24 hours or arriving more than 15 minutes past your appointment time could also result in the \$45.00 fee. Three of these occurrences could result in dismissal from the practice.
- Any checks returned by the bank will be charged a \$35.00 return check fee.
- Custom Products: Failure to pick up custom products within 30 days from initial contact by the office stating that the product has arrived, will result in the patient or their responsible party being held financially responsible for the entire purchase price of

the custom product. All deposits are non refundable.

Under the Americans With Disability Act, we take responsibility in providing services to you. These services have strict cancellation guidelines/policies. If services have been provided for you, you must contact our office or the inter-agency at least 48 hours in advance of your appointment time if a cancellation is needed. If you fail to do so, the fee you may incur \$130.00 per occurrence. We are happy to provide this service to you. We ask that you take the responsibility to properly inform us if you need to cancel or reschedule an appointment with our office.

Full Mth day, Year

Thank you for your cooperation and continued patronage. Please contact us at 717.757.3537 ext 7005 if you have any policy questions.

(Patient/ POA / Responsible Party Signature)

Patient's Name: Pat Whole Name (First Name First)
updated 01.02.2022