FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. Our goal is to provide you with the quality care in a friendly comfortable atmosphere and in the timeliest manner as possible. This information is designed to guide you throughout the rapidly changing world of medicine and insurance plans. Please read carefully and sign at the bottom of this page indicating your understanding of our policies and procedures. We accept cash, check, Visa and MasterCard.

OFFICE RESPONSIBILITY

1. An exact fee cannot be determined until after the Doctor has seen the patient and has reviewed the findings of that visit and any future visits. The Doctor will obtain verbal consent before rendering any additional services. You must realize that there is a separate charge for office visits, x-rays, injections, cast changes, and any other procedure done within the office or hospital setting.

2. As a courtesy to you we will bill your insurance company and supply them with all the necessary information they will need to accurately process your claim. **Your signature below will indicate your compliance for us to furnish your insurance with this information for processing and payment of our services.**

3. Our staff will treat you with respect and provide you with the best possible care through out your treatment.

4. Delinquent accounts may be referred to Professional Business Bureau. If you are experiencing financial difficulties we will work with you to arrange a payment plant to fit your budget. However, failure to pay a patient balance may result in termination of the physician-patient relationship.

PATIENT RESPONSIBILITY

1. We believe your time is as valuables as ours is, please arrive on time for your scheduled appointment. If you are more than 15 minutes late it may be necessary to reschedule your appointment for a later time.

2. It is the ultimate responsibility of the insured to understand his/her insurance coverage. Our staff cannot call your insurance company to obtain information regarding your benefits. Insurance policies may change and/or insurance company representatives may also give us incorrect or inconsistent information. Please verify with your insurance if our physician participates with your insurance. **It is your responsibility to obtain proper referral/authorization for your treatment at Summit Podiatry Group**. This must be presented at the time of service. Failure to have this information at the time of service may result in your being responsible for the charge of services performed.

3. Patients are responsible for their services not covered including: office visits, co-pays and/or deductibles at the time of services are rendered. If you are unable to pay for these services at the time of your appointment, our office will charge to your account a $20.00 billing fee each month for sending you a statement.

4. In the event that we are forced to submit a delinquent account to Professional Business Bureau, there will be a 40% collection fee added to your account. For example, if your unpaid balance is $100.00 and your account is referred to the collection agency, you will have to pay $140.00.

We thank you for understanding our financial polices. If you have any questions, feel free to ask us. We will be glad to help.

REGARDLESS OF ANY INSURANCE THAT I MAY HAVE, I AGREE THAT IT IS MY RESPONSIBILITY TO PAY ANY BALANCE DUE TO SUMMIT PODIATRY GROUP.

______________________	______________________	__________
Signature (patient/guardian)	Print name of signature	Date