Pueblo Ankle & Foot Care, PLLC
1619 North Greenwood St, Suite 300, Pueblo, CO 81003
Phone: 719-543-2476 Fax: 719-543-2479

FINANCIAL POLICY

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

INSURANCE: We participate in a number of insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. 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. We accept Medicare benefit amounts. Medicare, as well as your secondary insurance (if any and if we participate with them), will be billed for the services rendered to 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 coinsurance, which is 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 and if we participate with them).

SELF PAY: Payment in full is due at time of service.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or considered reasonable, or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: Some insurances require that you have a referral to be seen in our office. If you do not have a referral from your primary care physician at the time of visit, you will be financially responsible for all services received due in full upon completion of your visit.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. 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.

PATIENT BILLING: All co-payments, co-insurance, or deductible amounts must be paid AT TIME OF SERVICE. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients is considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

DURABLE MEDICAL EQUIPMENT PURCHASE: We require a deposit on some durable medical equipment and will bill your insurance company as well. If your insurance company pays, we will refund the deposit less any coinsurance or deductible deemed your responsibility. This will be done after the insurance payment has posted to your account.

CONTINUE OVER TO SIGN

NON-CUSTOM DURABLE MEDICAL EQUIPMENT AND OVER-THE-COUNTER PRODUCT RETURNS : If a patient is not satisfied with any non-custom Durable Medical Equipment or over-the-counter items purchased from Pueblo Ankle and Foot Care, it must be returned within 30 days as per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition, with original packaging, and with a receipt. If all conditions are met, a return will be processed through our billing department and a check for the amount, less any outstanding balance, will be issued. Any **custom** durable medical equipment item cannot be returned for any reason.

CANCELLATION/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. There will be a **$25 FEE** if you miss a scheduled appointment. Repeatedly missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to two notices of your financial responsibility (coinsurance, deductible, non-covered services) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. A $5.00 monthly billing charge will be added to all accounts over 60 days. After the second and last notice your account will be forwarded to our collection agency. A $15.00 fee will be added to collection accounts. You hold complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following methods: cash, check, VISA, Mastercard, Discover, and CareCredit. An additional $25.00 will be added to your statement if the check is returned from your bank.

I have read the above policy regarding my *financial responsibility* to Pueblo Ankle and Foot Care, for medical services provided. I agree to pay Pueblo Ankle and Foot Care any balances unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Pueblo Ankle and Foot Care, all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT TIME OF SERVICE**. 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 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.

PRINT Patient name:_____**Signature:**_____

Date of Birth:_____**Date:**_____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name:_____**Signature:**_____

Relationship to patient:_____**Date:**_____