1619 N Greenwood St., Suite 300
Pueblo, CO 81003
Phone: (719) 543-2476
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FINANCIAL POLICY

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

INSURANCE: We participate in a number of insurance plans. If you are insured by a plan we participate with, payment in full is expected 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 any co-insurance after the annual deductible is met, 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 payment in full for 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 form 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 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. We do not accept bills larger than $20. Payment at time of service 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 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 co-insurance or deductible deemed your responsibility. This will be done after the insurance payment has posted to your account. Any **custom** durable medical equipment item cannot be returned for any reason. Any custom orthotics that are not picked up will be subject to a $100 lab fee if the custom orthotics have already been made.

CONTINUE ON THE BACK 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 & 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.

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.

PATIENT REFUNDS: If there is a credit on your account that resulted in overpayment to Pueblo Ankle & Foot Care that is less than $20.00, it will *ONLY* be issued as a refund upon your request. Credits on accounts may be used toward future charges and/or product purchases. Credits greater than $20.00 will be processed as a refund either by a check in the mail, or processed back to the credit or debit card used at the time of service when payment was made to our office. If there is an outstanding balance on your account, credits will first be used toward the balance owed. Refund checks not cashed within 90 days may be re-issued for a $25.00 fee, which will be deducted out of the re-issued check before it is sent to you. Refunds will only be issued after the course of treatment is complete, and all insurance claims have been processed and finalized in the course of treatment.

COLLECTIONS FEES: You will be sent up to three notices of your financial responsibility (co-insurance, deductible, non-covered services) after payment and / or explanation of benefits (EOB) is received from your insurance(s). A $5.00 monthly billing charge will be added to all accounts over 60 days. After the FINAL 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 payment methods: cash, check, VISA, Mastercard, Discover, and CareCredit. Any payments that are disputed (check, debit, or credit card), or come back as insufficient funds or chargebacks will result in a $50.00 fee in addition to any bank fees that our office is charged. These fees, as well as the original charge on the account will be due immediately, and any prior payment arrangements will be eliminated. A $5.00 monthly billing charge will be added, and after the FINAL NOTICE, a $15.00 fee will be added. If the account is not paid in full, your account will be forwarded to our collection agency.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented above and assign directly to Pueblo Ankle & 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 have read the above policy regarding my *financial responsibility* to Pueblo Ankle & Foot Care, for medical services provided. I agree to pay Pueblo Ankle & Foot Care any balances unpaid by my insurance carrier for myself or the below named patient.

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:_____ Today's Date:_____

FINANCIALLY RESPONSIBLE PARTY:

***PRINT* NAME:_____ Signature:_____**

Relationship to Patient:_____ Today's Date:_____