

West Hartford Podiatry Associates Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy.

If you are a member of a contracted Managed Care Plan and you have chosen us as your Specialist, please be prepared to pay your co-payment at the time of your appointment. Most Managed Care plans require a referral from your Primary Care Provider. If at the time of service a valid referral with an authorization number was not received in our office from your Primary Care Doctor we will require all patients to sign a general release form. Medical supplies that are not normally covered by your medical insurance plan the patient will be required to pay in full at the time of the visit.

If you have an indemnity insurance plan with a carrier with whom we are contracted to provide services, such as Anthem Blue Cross/Blue Shield, we will bill your carrier for services rendered. You will be responsible for any coinsurance and deductible amounts after we have received an explanation of benefits from your carrier. Non-covered services and medical supplies, the patient will be required to pay in full at the time of the visit.

Patients who are covered by a Commercial Insurance Carrier, with whom we are not contracted, will remain responsible for their balance. We will courtesy bill your carrier. If we do not receive payment within 45 days, we will transfer the balance to your responsibility for payment. It will be your responsibility to follow up with your carrier for reimbursement. Non-covered services and medical supplies, the patient will be required to pay in full at the time of the visit.

Patients that do not have medical insurance will be required to pay for the services rendered in full on the date of service and will be asked to show proof of payment prior to treatment. We require payment in the form of cash, money order, bank check or visa/mastercard with a valid authorization. We will try to accommodate patients by supplying an estimate prior to seeing the Doctor. If you have any questions, please contact our Office Manager. Sorry, we do not do payment plans.

Medicare patients are required to meet a \$110.00 dollar calendar year deductible. Non-covered medical supplies or services, the patient will be required to pay in full at the time of the visit. If you have a supplemental or secondary insurance please advise us at the time of the visit and we can determine if we participate with that carrier.

Missed appointments: Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

x _____ date _____
Signature of Patient or Responsible Party

x _____ date _____
Signature of Co-Responsible Party