Palmetto Podiatry Associates, LLC

Patient Financial Responsibility Policy

Palmetto Podiatry Associates, LLC (PPA) appreciates the confidence you have shown in choosing us to provide for your podiatric needs. We are committed to providing you with the best possible care. The medical services you seek imply a financial responsibility on your part. It is important that you have a clear understanding of our financial policy. Should you have any questions regarding this policy please don't hesitate to ask at the front desk.

CO-PAYMENTS/CO-INSURANCE & DEDUCTIBLES ARE DUE ON THE DAY OF SERVICE.

CO-PAYS: Your insurance plan determines your co-pay amount. **THEY** require that we collect your designated co-pay at the time of service. If you do not have your co-payment amount at the time of service your appointment may have to be rescheduled.

SELF PAY: You will be considered a self-pay patient if you have no insurance coverage. Payment is expected at the time of service. A $100.00 deposit is required at the beginning of your appointment with any balance to be paid after.

MEDICARE: PPA will submit your claim to Medicare and upon receipt of benefits, bill your secondary insurance, if applicable. Please be aware that your deductible amount may change from year to year. The patient is responsible for the deductible and co-insurance if you do not have a secondary policy.

REFERRALS: Your insurance plan may require a referral from your Primary Care Physician (PCP). It is the patient's responsibility to obtain the referral PRIOR to your appointment. Please have the written referral from your PCP with you at the time of your appointment OR confirm that our office has received it via fax. If the referral is NOT available at the time of your appointment YOU MAY BE REQUIRED TO RESCHEDULE.

INSURANCE & ID: Please have your insurance card and picture ID available. If you do not have these at the time of your appointment our office may need to reschedule your appointment.

NON-PARTICIPATING INSURANCE PLANS: As a courtesy to our patients, PPA will bill your non-participating insurance plan. IT IS ULTIMATELY THE PATIENT'S RESPONSIBILITY TO VERIFY IF PPA IS IN-NETWORK OR A PARTICIPATING PROVIDER WITH THEIR INSURANCE PLAN. Any outstanding balances are the responsibility of the patient.

RESPONSIBLE PARTY: When the patient is a minor (child) the parent that signs for services will be responsible for all outstanding charges.

NON COVERED SERVICES: As part of your treatment your physician may prescribe Durable Medical Equipment (DME). PPA will make every effort to authorize this service, if applicable, with your insurance company. In the event your insurance company denies this item, or you do not have DME benefits, YOU WILL BE RESPONSIBLE FOR ANY BALANCE. **DURABLE MEDICAL EQUIPMENT IS NON REFUNDABLE AND CANNOT BE RETURNED.**

DISABILITY/FMLA/INSURANCE FORMS: Please allow 7-10 business days for all forms to be completed. OUR OFFICE will contact you when the forms are ready for pick up. There is a $25.00 fee for all completed forms.

MEDICAL RECORDS REQUEST: For the privacy and protection of our patients, we require a signed authorization for all medical records requests. Please allow up to 30 days to fulfill your request. There is a $15.00 copying fee for this service.

RETURN CHECK FEE: There is a $30.00 fee for any check returned from the bank due to insufficient funds, closed account, etc.

BROKEN/NO SHOW APPOINTMENTS: If you are unable to keep your appointment please give our office 24 hour notice. Be advised, if no notice is given you will be charged a $30.00 fee for any broken appointment.

LATE FOR YOUR APPOINTMENT: If you are more than 20 minutes late for your scheduled appointment our office will need to reschedule.

FINANCIAL RESPONSIBILITY OF PATIENT: I understand that my signature below indicates that I am responsible for any and all outstanding balances on my account or any for which I am the Responsible Party. Further, I agree to pay all outstanding balances in a timely manner. I understand that if I do not make payment for services owed, PPA will take necessary and appropriate action to collect monies due through a collection agency or attorney. This may affect your credit negatively. I hereby authorize PPA to release all medical information to insurance carriers and/or Center for Medicare/Medicaid concerning my illness and treatment and I assign payment to PPA for services rendered to myself or dependent. I understand **I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE.**

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Signature of Patient, POA or Guardian Date