

Financial Policy - Payment Policy

Thank you for choosing West Hartford Podiatry Associates as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided upon your request.

- **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
 - **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit when required.
 - **Non-Covered Service.** Please be aware that some -- and perhaps all- of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurances. You must pay for these services in full at the time of visit.
 - **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full or will be required to reschedule their appointment after the proper referral is obtained.
 - **Claims 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.
 - **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
 - **Nonpayment.** Statements are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware if your balance remains unpaid, we may refer your account to a collection agency and you may be discharged from our office.
 - **Missed appointments.** Please help us serve you better by keeping your regular scheduled appointments. 24 hrs. notice for a cancellation is required.
 - **Fees.** Our fees are representative of the usual and customary charges for our area.
- Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature: _____ Date _____