COLORADO FOOT and ANKLE

2020 Patient Payment Policy

Dear Patient:

The doctors and staff at Colorado Foot and Ankle would like to welcome you to our practice. Below are the financial responsibilities of our patients.

Payments: We accept cash, check, Visa, MasterCard, American Express or Discover. A credit card will be requested and placed on file. All insurance co-payments, co-insurances and deductibles will be collected at the time of service prior to treatment. If you do not have your payment(s), your appointment may be rescheduled and a cancellation fee charged.

No Insurance: If you have no insurance, we collect a $200 deposit for your initial office visit and $100 on your follow up visits. All services will be billed according to the current self pay charge sheet and all transactions will be completed prior to leaving the office. (Note: there may be additional charges to your office visit if x-rays or procedures are required.)

Outstanding Balances: We may refuse to see patients with balances over $250, who have not made prior arrangements with our billing department. Any and all balances, regardless of insurance coverage, are **due within 60 days** of the date of service, unless prior arrangements are made. Any unpaid balances older than 60 days may be subject to account maintenance and finance charges of $35 per month. Returned checks will result in a $30 service charge and payment of all fees incurred resulting from the returned check. Disputes resulting from unpaid balances are agreed to be settled by mediation at your expense and request. If the account is referred to a collection agency, you the patient (or guarantor of the patient) shall pay an additional collection fee of at least 50% of the principal balance plus reasonable attorneys' fees and all Court costs of the other party incident to any action brought to enforce this Agreement.

Refunds: Refunds due to overpayment will be issued within 4-6 weeks from the date requested. Refunds will be held until all outstanding insurance claims or balances are paid in full. Any refund amount under $25 will not be refunded due to the overhead cost involved. All products and orthotics purchased from our office are medical grade and Non-Refundable.

Cancellations: Please notify us at least 24 hours in advance if you need to cancel or change your regular appointment (5 business days for surgery). There will be a $50 charge for regular appointments and a $250 charge for surgical appointments in the event that you do not show up at your scheduled appointment time, cancel or change your appointment without 24 hours notice (5 business days for surgery). Notification allows the doctor to care for another patient during that time.

Forms/Letters/Medial Records: There is a $30 charge for the completion of paperwork (ex: disability, FMLA, work releases etc.). We charge a $25 copy fee for medical records requested for personal use and $25 copy fee for x-rays. Letters completed on your behalf will be charged at a rate consistent with the doctor's time spent creating the letter. Please allow up to 5 business days for the completion of your disability, FMLA or work release paperwork.

Workers Compensation: If your claim is denied you will be responsible for payment in full. Outstanding balances follow the same rules and timeframes as above. Out of State claims will be handled only if first approved by the physician rendering treatment.

Auto Accidents/Personal Injury: Payment is due in full at time of service.

If you have health insurance coverage: As a courtesy to our patients, we will submit your insurance claim(s), however, **we must emphasize that as medical providers, our relationship is with you and not your insurance company.** Although we attempt to verify benefits with your insurance policy, please be advised any quote of benefits provided by your insurance company is considered a general overview, and only a guideline until final coverage determinations are made and payment is received.

This office makes **NO** guarantee of benefits.

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services provided in our office are a covered benefit under all insurance plans.
- If your insurance policy requires a referral of any type, it is your responsibility to have that referral sent to our office prior to your appointment. Without an appropriate referral you are solely responsible for payment.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy. You are responsible for any non-covered or denied service by your insurance policy.
- Most insurance companies require preauthorization before you have a surgical procedure. Failure to obtain preauthorization may result in refusal of payment by insurance and becomes your responsibility.
- We do not enter into disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider.
- Our office does participate with some insurance plans out of network and benefits may be different from in network benefits

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **We are here to help you.**

I have read and understand the above Patient Payment Policy and agree to meet all financial obligations as outlined regardless of my insurance status. I acknowledge that these policies do not obligate Colorado Foot and Ankle to extend credit.

_____ _____

Patient Name (Please print) Patient Signature

_____

Date

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CREDIT CARD AUTHORIZATION (circle one) Visa MasterCard Discover Am Express

Card Number: _____ Exp Date: _____

Name on Card: _____ Signature: _____

I understand it is the policy of Colorado Foot and Ankle to secure my credit card information at the time of my visit. Colorado Foot and Ankle has my permission to charge my credit card for the entire amount owed for treatment and/or services provided to me or my dependent. (1)The claim is denied as a non-covered service by my insurance carrier (2) The charges are not paid (or only partially paid) by my insurance carrier, (3) Charges associated with appointments that are not cancelled within the timeframes listed above, (4) Charges associated with payment arrangements, (5) Any outstanding account balance over 60 days from the date of service. I hereby authorize Colorado Foot and Ankle and its designated employees to charge my credit card the full amount of all charges made for medical treatment and services provided and the amount charged to my credit card will be reflected on my credit card statement. The charge will be based on the medical treatment rendered to me (or, my dependent) and the usual and customary charges made for such treatment and service. I understand that in the event my credit card has been charged for medical treatment or services, and then my insurance carrier subsequently makes payment for those charges, the office will issue a credit to my credit card in the amount received from my insurance carrier. This authorization shall remain effective unless expressly revoked by me in writing, delivered to the offices of Colorado Foot and Ankle at 455 East Pikes Peak Ave., Suite 220, Colorado Springs, Co 80903.