# Stockdale Podiatry Group, Inc.

MEDICINE AND SURGERY OF THE FOOT AND ANKLE

**OFFICE POLICY**

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Thank you for choosing Stockdale Podiatry Group for your foot and ankle health. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. Please understand that payment of your bill is part of this treatment and care. Listed below, please find our current financial policy:

**INSURANCE:**

We participate in most insurance plans. 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 are able to verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and be aware that your insurance benefit is a signed contract between you and your insurance company.

**MEDICARE:**

We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare, as well as your secondary insurance (if applicable) will be billed for you. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments/coinsurance.

**SECONDARY INSURANCE:**

Your medical claim will be forwarded to your secondary insurance (if applicable) after payment and/or an explanation of benefits (EOB) has been received from your primary insurance company.

**SELF-PAY:**

Payment in full is due at the time of service if you are not currently covered under a health insurance plan.

**NON-COVERED SERVICES:**

Please be aware that some of the services you receive may not be covered or not considered reasonable or medically necessary by Medicare and/or other insurers. You are responsible for full payment for these services at the time of service.

**PATIENT BILLING:**

ALL co-payments must be paid AT THE TIME OF SERVICE. This arrangement is part of your contract with your insurance company. 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. Failure to pay your co-payment at the time of your visit will result in a $5.00 billing surcharge. Additionally, returned insufficient payment with check, credit or debit, will be the responsibility of the patient and an additional fee (bank fee) of $30.00 will be added if payment is returned.

**REFERRALS/AUTHORIZATIONS:**

Our office is required to follow the guidelines of your managed care plan, which mandates that upon visiting a specialist, such as ours, you must have an authorization from your primary care physician (PCP) prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your authorization is presented at the time of visit.

**PATIENT CANCELLATION AGREEMENT:**

Our office requires twenty-four (24) hour notice for all patients canceling and/or rescheduling office visits. If our office does not receive twenty-four (24) hour notice you will be charged a $35.00 fee for the missed office visit. If you arrive over fifteen (15) minutes late to your scheduled appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred.

**ASSIGNMENT OF BENEFITS:** I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Stockdale Podiatry Group all insurance benefits payable to me for services rendered. I understand that I am responsible for payment of co-payments, non-covered services, and other fees AT THE TIME OF SERVICE. I hereby authorize Stockdale Podiatry Group to release all information necessary to secure payment of benefits. I authorize Release of Medical information to my insurance carrier, or requested doctor, to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform Stockdale Podiatry Group if there are any changes in my health insurance information. I acknowledge that I was provided with and/or offered a copy of the Notice of Privacy Practices and understand and accept its terms.

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| **Print Name** | **Signature** | **Date** |

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| **Financially Responsible Party** | **Relation** | **Signature** | **Date** |