FINANCIAL POLICY

1. **Insurance.** We participate with most major insurance plans, including Medicare. Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions. If we participate with your insurance carrier, all services provided in our office (unless otherwise indicated) will be submitted to your insurance.

   If we do not participate with your insurance or if you do not have health insurance, payment in full is expected from you at the time of your visit. You may also inquire about the payment plans that may be available.

2. **Proof of Insurance.** All patients must complete our patient registration forms before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.

3. **Co-payments and Deductibles.** In accordance with your insurance plan and services provided, you are responsible for any and all co-payments, deductibles, and coinsurances. Copays, deductibles and coinsurance are due at the time of service.

4. **Referrals.** In accordance with your insurance carrier it is your responsibility to know if a written referral is required to see a specialist, or for a certain procedure. When a referral is not presented at the time of service to the provider, the patient may be responsible for payment in full at the time of service.

5. **Claims Submission.** Submission of claims is a courtesy extended to our patients. If your insurance company does not pay your claim, the balance will be billed to you. You agree to assign your insurance benefits to The Frankel Foot & Ankle Center, Dr. Frankel and/or associates/partners.

6. **Non-covered Services.** Certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic" or simply "non-covered" by your insurance carrier. You are responsible for payment of these services. In the event your care exceeds a plan limitation, the balance becomes your responsibility.

7. **Non-payment of patient balances.** Should your account become delinquent, the patient or guarantor agrees to pay all costs associated with collecting the balance due including, but not limited to, attorney, collection, and contingent fees.

8. **Non-sufficient funds (NSF)/ Returned Checks.** A fee of $35.00 will be charged for all returned checks.

9. **"No Show" and Cancellation Policy:** If an appointment is missed without a notifying phone call with 24 hours' notice ("no show"), a $25 fee will be charged (this is not covered by your insurance). If an appointment is cancelled with less than 24 hours notice, we reserve the right to charge a $25 fee (not covered by your insurance). If, however, this appointment is rescheduled for another time that day or another day that week the fee will not be incurred. If 3 cancellations occur you may be discharged from our services. **I acknowledge, understand and agree to comply with this financial policy.**

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Patient Signature Date