



Ankle & Foot Clinic of Oregon
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BILLING FINANCIAL POLICY

Thank you for choosing our physician and staff to provide for your foot and ankle needs. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a financial policy.

The following is a statement of our **FINANCIAL POLICY** which we request you read and sign prior to any treatment. To avoid any misunderstanding, please contact us should you have any questions about our policies, services, or fees.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company for you. To do this we must have complete and accurate insurance information and a copy of your insurance card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding participating provider status, pre-authorizations, obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service. Please know that your office visits, diagnosis, and treatments are billed separately. In order to prevent insurance fraud, we will ask to take a picture for patient verification and to properly identify you. In addition to this, your picture will not be shared anywhere else, strictly for our office only.

NO INSURANCE/SELF PAY: If you do not have insurance or if the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment. Should you have any questions before rendering a treatment, please talk to our billing department.

PAYMENT: Payments for the balance due and co-payments are due at the time of service and may be made by cash, check, or credit card (Visa, Mastercard, American Express, and Discover). There will be a \$25.00 charge for returned checks. Delinquent accounts (90 days) will be assigned to a collection agency and will incur a 25% collection charge. Please call our office immediately if you are unable to pay your balance in full.

CO-PAYMENTS: Please be prepared to pay all co-pays at the time of service. Co-pays are the amount an insured person is expected to pay for a medical expense at the time of the visit. Co-pays are a personal responsibility and have been determined by your contract with your insurance company.

DEDUCTIBLES: Many insurance companies have annual deductibles. A deductible is the amount you must pay toward a claim before your insurance begins to pay. The amount is a contract between you and your insurance company. It is your responsibility to pay for services that have been applied to the deductible expense.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the changes and treatment. Young adults (age 18 and over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

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ORTHOTICS: Orthotics is a non-covered service by some insurance plans. Please check with your insurance company prior to the examination and casting for orthotics to determine your orthotic benefits. A deposit of \$100 is requested at the time of the examination and casting and full payment is due when the orthotics is dispensed.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. We cannot bill for these items.

CANCELLATION/NO SHOW POLICY AS OF 2017: Patients who do not show up for their appointment without a call to cancel an office/procedure appointment at least 24 hours in advance will be considered as NO SHOW. Cancellation and No Show fees are sole responsibility of the patient and must be paid in full before the patient's next appointment.

- If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$30.00 fee; this is not a billable item to your insurance company.
- Due to large block of time needed for surgery, late cancellation/no shows for surgeries will incur \$100.00 fee; this is not a billable item to your insurance company.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. We make reminder calls one workday prior to your appointment to promote a healthy culture in these matters. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

We thank you for your understanding and we look forward to continuing to provide the best possible care for your podiatric needs.

As a reminder, please be prepared to pay your copayment at the time of the visit.

I HAVE READ AND AGREE TO THE TERMS SET FORTH IN THE BILLING FINANCIAL POLICY. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE.

Please sign and date below:

X _____
(Signature of patient, beneficiary, Guardian of minor patient, or personal representative)

Date: _____