LAKE OSWEGO FOOT CLINIC
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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 carefully 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 IN-NETWORK: If our provider is a participating provider with your insurance plan, we will submit a claim to your insurance as a courtesy to you. To do this we must have complete and accurate insurance information and a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. Therefore, you are ultimately responsible for payment whether your insurance company pays or not. 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. Please know that your office visits, diagnosis, and treatments are billed separately.

INSURANCE OUT OF-NETWORK: If we are out of network with your insurance, please check for any out of network benefits and we will file a claim for you as a courtesy. Out of network benefits pay at a lower percentage which means your out of pocket cost is more versus your in-network benefits.

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 a treatment is rendered, please talk to our billing department.

PHOTO ON FILE: 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 use only.

PAYMENT: Payments for the balance due and co-payments are due at the time of service and may be made by cash, check, credit card (Visa, Mastercard, American Express, and Discover) and we also accept care credit. 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 beings 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.

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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.

CUSTOM ORTHOTICS: Orthotics is a non-covered service by some insurance plans, such as Medicare Part B. Some insurance plans will require a prior authorization after examination. Our office will submit a pre-determination/prior authorization to your insurance which typically takes about 7-14 days to hear back if it's been approved or denied. We will do our best to supply your insurance company with all the necessary medical documentation and check your benefits. **PLEASE NOTE: Preauthorization and predetermination approval does not mean guaranteed payment. It is a required process our office must initiate in order to proceed with this service.** A deposit of $100 is required at the time of casting and payment is due in full at the time of dispense if you do not have insurance coverage.

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.

FMLA (Family Medical Leave Act) FORM CHARGE: If an FMLA document needs to be completed by the provider, there will be a charge of $40. Under federal law, employers are not required to pay for fees charged for FMLA, that it is the responsibility of employee.

CANCELLATION/NO SHOW POLICY: 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:_____