Patient Name:_____Date:_____

A WORD ABOUT INSURANCE COVERAGE

Mattison Podiatry Group appreciates the confidence you have shown in choosing us to provide your foot care needs. The insurance you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. This financial policy contains important details about billing and payments for our professional services. It outlines your responsibility concerning billing and payment for our services.

ROUTINE FOOT CARE: **(cutting of nails, corns, calluses) This service is only covered by insurance when there is a medically necessary diagnosis such as (Diabetes, Blood thinners, Multiple Sclerosis, Neuropathy).**

INSURANCE: Mattison Podiatry Group participates with most insurance plans, including Medicare. If we participate with your plan we will bill the insurance carrier directly and you will be responsible for co-payments, deductibles, non-covered services, ect. Please remember that your insurance coverage is a contract between you and your insurance company. Insurance policies often do not provide full payment of medical costs, and you are responsible for any services which your insurance plan does not cover. Contact your insurer directly with any questions regarding your coverage. Medicare patients are responsible for their 20 % co-insurance and yearly deductible. Having secondary insurance does not mean that your services are covered at 100%. Secondary insurance will pay based on your primary carrier. We will bill your secondary as a courtesy and you will be responsible for any balance. Our office does not bill a tertiary or third insurance company.

REFERRALS: Insurances sometimes require their members to obtain a referral for treatment from a specialist. Please be aware that it is your responsibility to obtain any referral if needed. In the absence of the required authorization or referral you will be responsible for 100% of the charges for your visit at the time of your visit.

CO-PAYMENTS: Co-Payments, coinsurance, deductible and any service not covered by your insurance plan are your responsibility, paid at the time of service.

NON PAYMENT: If your account becomes more that 90 days past due, you will be required to pay your account in full within 10 days. Payment arrangements can be made with our billing office if you are unable to pay in full.

MISSED APPOINTMENTS: If you need to cancel an appointment, please give our office as much notice as possible so that we may allow other patients to utilize the appointment.

RETURNED CHECKS: You will be charged a $25 fee for a returned check if it is returned for non-payment/insufficient funds.

We accept: CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER

I have read and understand the payment policy and agree to abide by its guidelines.

*Signature*_____***Date:***_____
(signature of patient or responsible party)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was made aware of the Notice of Privacy Practices and can receive a copy of them at any time. I acknowledge that I have read or had the opportunity to read it if I so choose; and understand the notice.

_____**Date:**_____
Patient Name (please print)

_____
Signature

_____
Parent or Authorized Representative (if applicable)