

Middle Tn. Foot and Ankle Clinic Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our Office Policy, allows for a good flow of communication and enables us to achieve our goal. We make every effort to keep down the cost of your medical care. Because the billing process has become so expensive and because we all wish to keep medical costs as low as possible, we have established this financial policy (effective 6/25/9).

COPAYS ARE EXPECTED AT THE TIME OF SERVICE: Your insurance requires by law that we collect your co-pay. Please expect to pay your co-pay on every visit. For your convenience, we accept cash, check, and most credit and debit cards.

INSURANCE: Please bring your insurance card to every visit. **We bill participating insurance companies as a courtesy to you. You are responsible for all charges.** Our participation with various insurance companies is subject to change. It is your responsibility to contact your insurance company or your employer's HR department to see if we are participating providers. We are not held responsible for out of network payments from your insurance company. It is also your responsibility to know if a referral or authorization is required for your visit with us. You may also want to call your insurance company to check coverage for podiatric services.

SELF-PAY: If you are uninsured, the initial cost to see the physician is \$100.00 and is collected before seeing the physician. If there are other charges, such as x-rays, surgeries, etc., you may be billed for these services if unable to pay for them at the time of service. **Consistent monthly payments must be made to prevent your account from being turned over to a collection agency.**

SURGICAL DEPOSITS: If you are scheduled to have surgery, you may be asked to pay a deposit. We call your insurance company and analyze your benefits to approximate how much you will be responsible for after your insurance company pays. This is an estimate and any overpayment will be refunded at the end of the month after all claims have been paid.

RETURNED CHECKS: A \$20.00 fee will be charged for any check returned for insufficient funds. You will be notified by mail or phone if we receive a returned check. You will be expected to come by our office to pick up the check and pay the fee in addition to the amount of the check, in cash. We will not run checks back through. If you fail to comply or we are unable to contact you, your account will be turned over to a collection agency.

MISSED APPOINTMENTS: Effective 6/1/09, our office instituted a \$25.00 fee for missed no-show appointments. This has been made necessary by increasing numbers of people not keeping their appointments. Broken appointments represent a cost to us, to you and to other patients **who could have been seen in the time set aside for you.** This fee is not covered by your insurance company and will apply if you fail to notify us of a cancellation at least 24 hours prior to your scheduled appointment time. If you need to cancel an appointment please call as soon as you know during business hours. **EXCEPTIONS WILL BE MADE DEPENDENT ON MEDICAL CIRCUMSTANCES.**

MEDICAL RECORDS: You will be charged \$20.00 for copies. You will also be charged for the cost of postage, if you request copies be mailed. No charge will apply when sending records to insurance companies or other physicians.

ADMINISTRATIVE FEES: There is an administration fee of \$20.00 for the filling out of forms, such as disability or FMLA papers.

BILLING: You will be billed for any remaining balance that you may owe after your insurance company has processed the claim. Unless financial arrangements are made in advance, any accounts over 60 days will need to be paid before your next appointment. **Consistent monthly payments must be made to prevent your account from being turned over to a collection agency.** Any accounts over 60 days old will be turned over to a collection agency and you will be responsible for all collection fees and court costs. If you have any questions, please do not hesitate to call our office manager at 931-380-0353.

I have read and understand the above Office Policy. I have a copy for my records.

SIGNED _____ DATE _____