Accurate Foot and Diabetic Care
520 Maple Ave Suite 1
West Chester, PA 19380
610-436-5883

Springfield Podiatry, LLC.
648 Childs Ave
Drexel Hill, PA 19026
484-521-0233

PATIENT FINANCIAL POLICY *Update January 2017*

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with the front office staff. **You are going to be receiving a complete total foot and ankle evaluation**. If you receive a bill, please make sure that you have your explanation of benefits ("EOB") handy when you call the office and speak to the billing person. We cannot help you unless you have that EOB available. Please initial this area _____, to indicate that you understand your financial responsibility.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

- Unless other arrangements have been made in advance by you or your health insurance carrier, **payments for office services are due at the time services are rendered.** We will accept Visa, MasterCard, Discover, cash or check. **If you do not pay your co-pay at the time of your visit a $10 billing fee will be added.**

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim to your primary insurance and your secondary insurance if you are a Medicare patient. **We will not file claims for two primary insurances.** We will help you with your second primary insurance if we can. As a courtesy, we will also file your insurance claim for you if you assign the benefits to the doctor directly. In other words, you agree that, if the insurance company does not pay the practice within a reasonable period of time, it will be your responsibility to make the payment.

- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those insurers and plans with which we have an agreement and will require you to pay the co-pay and/or coinsurance/deductible at the time office services are rendered.

- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim to the insurer for you on an unassigned basis. This means that your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time office services are rendered.

- **We try to determine if we are in the network of providers for your insurance plan. Sometimes we are told we are in the network of providers, but when we send the claim in to the insurance company we are told we are not in the network. It is your responsibility to make sure we are in your insurance network. If we are not in your insurance network, then you are fully responsible for payment based upon the explanation of benefits from the insurance company.**

- All health plans are not the same and do not cover the same services. In the event that your health plan determines that a service is "not covered", or that you do not have authorization for a service, you will be responsible for the complete charge for that service. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges for any office services rendered. Patients are encouraged to contact their plan for clarification of benefits prior to office services being rendered.

- You must inform the office of all insurance changes in plans and/or authorization/referral requirements. In the event the office is not informed of a change in your insurance and/or your authorization/referral requirements, you will be responsible for any charges that your insurer denies.

- For most services performed in the hospital, we will bill your health insurance plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is a procedure requiring prepayment. In such a case, payment will be due one week prior to the surgery.

- **Past due accounts are subject to collection proceedings. A late fee of $15 will be assessed if payment is not made by the due date. All costs incurred by the office, including, but not limited to, collection fees, attorneys' fees, court fees, and the monetary value of any time that the office manager and/or physicians spend going to court to collect amounts owed, shall be your responsibility in addition to the balance due to this office. Initial _____**

- **In the event that you dispute any of the charges for services rendered, and the office successfully defends against your claims, you shall be responsible not only for the balance due to this office, but also for all costs incurred by the office in defending against your claims, including, but not limited to, attorneys' fees, costs, court fees, and the monetary value of any time that the office manager and/or physicians spend going to court to defend against your claims. Initial _____**

- **There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee. If a check is returned to the office you will no longer be able to use a check for payment.**

Signature of patient/responsible party: _____

Printed name of patient/responsible party: _____

Witness signature: _____

Printed name of witness: _____ Date _____