MILL CREEK FOOT AND ANKLE CLINIC
STATEMENT OF BILLING/CREDIT/NOTICE OF INFORMATION POLICIES
FOR THE BENEFIT OF OUR PATIENTS

FOR OUR CONTRACTED INSURANCE PLANS:
We accept payment based on insurance company's allowable fee structure and the contract your insurance group has with the carrier. Any allowable balances are the responsibility of the patient and are due in full upon receipt of statement.

It is the patient's responsibility to obtain any necessary referrals. If no referral is received by your appointment date, we will request you either reschedule or sign a waiver and pay for your visit at that time.

The patient is responsible for all account balances, even with insurance benefits. We will bill your insurance as a courtesy to you, but cannot guarantee your benefits. If your insurance company informs us of any benefits you are, or are not, entitled to, we will advise you of the same. Any oral representation we make in good faith to you concerning your insurance is not binding on us and will not in any way or for any reason be considered a modification of this billing notice.

INSURANCE CO-PAYMENTS:
Co-payments are due at check-in for your appointment. Your co-payment is determined by the insurance plan you have selected, Mill Creek Foot and Ankle Clinic in no way determines the co-pay amount and is required by contract to collect the co-pay at time of visit.

MEDICARE:
We accept assignment for our Medicare patients and will bill Medicare for you. Do not submit a claim yourself. Medicare pays 80% of their allowable fee after you have satisfied your yearly deductible amount. If you have supplemental insurance we are required to provide Medicare with this information. In most cases Medicare will forward your claim directly to you supplemental insurance for you.

Medicare does not pay for orthotics. Patient must meet very specific requirements for Medicare to cover foot/nail care, and it is only covered every 61 days. They also can limit the number of visits per diagnosis. It is the patient's responsibility to pay for services not covered by Medicare. You are required by Medicare to sign a waiver, when appropriate, indicating that you have been informed that Medicare may not cover certain services and that you accept the financial responsibility yourself.

FAILED AND CANCELLED APPOINTMENTS:
Patients who fail to show or cancel their appointment without giving our office 24 hour notice may be charged $25.00 for the first time and $50.00 for each time thereafter for office visits and $200.00 for surgeries/office procedures.

METHODS OF PAYMENT:
We accept cash, personal checks, money orders and MasterCard/Visa. For any balances, we expect payment in full, upon receipt of statement. For larger balances, we may consider reasonable monthly payments, however, this plan must be agreed to prior to treatment being rendered.

Fees: Patient will be charged a minimum of $25.00 administrative fee for us to complete Disability, FMLA, Job capacities/work related forms.

Durable Medical Equipment (Custom Orthotics, Surgical Boot/Shoe, Cam Walkers, Aquashield, Spencos, Orthotic Recovers)
Orthotics: Patient is responsible for calling their insurance company for coverage information. As a courtesy to you our office will also call for coverage information. Any oral representation we make in good faith to you concerning your insurance is not binding on us and will not in any way or for any reason be considered a modification of this billing notice. Payment will be due in full before orthotics are dispensed If not a covered benefit by your insurance. **Surgical shoe/Removable casts, will be billed to your insurance, they may or may not be a covered benefit. Aquashield, Spencos, Orthotic Recovers –are to be paid for upon dispense.**

I have read and understand this policy and acknowledge full responsibility for the payment of services rendered. I authorize all payments to be made directly to Mill Creek Foot and Ankle Clinic or my provider on my behalf for any services or supplies furnished by my doctor or Mill Creek Foot and Ankle Clinic and for my doctor to act as my agent to help obtain payment. I authorize the release of medical information or documentation in their possession about me to all my insurance companies as well as to Medicare in order to determine benefits of the benefits payable for related services, now or in the future.

Signature _____ Date _____

Name (please print) _____ Copies Available upon request