

Foot Care Associates of Texas
Dr Michael Wynn
23972 A Hwy 59 North Kingwood, TX 77339

OFFICE POLICY

In order to reduce confusion and misunderstanding between our patients and Foot Care Associates of Texas, P.A., we have adopted the following financial policy. If you have any questions regarding this policy, please discuss them prior to being seated.

Unless arrangements have been made with your insurance carrier, payment in full is due at the time of visit.

If payment is made by cash, please make sure you receive a cash receipt!

NO CELL PHONES IN THE OFFICE, WE HAVE EXPENSIVE EQUIPMENT THAT CAN BE INTERFERED WITH. \$25.00 WILL BE CHARGED FOR FAILURE TO COMPLY!

YOUR INSURANCE

Our office is under contract with Medicare and most insurance companies. You will be responsible for co-pays, deductibles, and non-covered services at the time of service.

Insurance companies always give a disclaimer stating that nothing is guaranteed for payment until the claim is received. When we receive the Explanation of Benefits from your insurance company, any balance shown as your balance, will be billed to you.

Surgical care will be discussed with you prior to scheduling any procedures.

If your insurance company requires a referral from your Primary Care Physician on record and you arrive without the referral, you will not be seen. It is your responsibility to know and comply with the guidelines of your insurance.

A service charge of 1% per month, 12% APR will be billed to all overdue accounts. Accounts will become delinquent after 60 days unless payment arrangements have been made and paid according to agreement. You will also be liable for all legal and collection fees.

REGARDING X-RAYS

X-rays taken in our office are a permanent part of your chart. The charges billed are for the interpretation of your problem by the doctor. No copies can be made of the x-rays. However, Dr. Wynn will notate in the charts notes of the findings of the x-rays.

ASSIGNMENT OF BENEFITS

I authorize insurance claims to be filed on my behalf and to have payment assigned to Foot Care Associates of Texas, P.A.

Patient Name (please print)

Parent or Authorized Representative (please print, if applicable)

Signature

Date