

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 questions regarding this policy, please discuss them with the Patient Care Co-ordinator prior to being seated.

Unless arrangements have been made with your insurance carrier, payment in full is due at the time of service. Payment may be made by cash, check or the following credit cards: MASTERCARD, VISA, AMERICAN EXPRESS.

YOUR INSURANCE

Our office is under contract as a network provider with Medicare and several insurance companies. We have made prior arrangements with these carriers to accept assignment of benefits for routine procedures. You will be responsible for your co-payment and/or non-covered expenses at the time of service.

Insurance companies assign fees to specific procedures which the insurance company considers "Reasonable and Customary". We have no control over these fees and any balance that is the patient responsibility will be billed to you.

All aspects of pre and post operative surgical care will be discussed fully with you, as well as fees for services rendered and any payment options available to you.

If your plan requires a referral from your primary care physician for your treatment and you arrive without this referral, you will be responsible for your total charges at the time of service or you may reschedule your appointment after this has been obtained. It is your responsibility to comply within the guidelines of your plan.

A service charge of 1.5% per month, 18% APR will be added to all overdue accounts. Also liable for all legal and collection fees.

REGARDING X-RAYS

X-rays that are taken in this office are to become a permanent part of your chart. The charges for the X-rays are for the interpretation of your problem by the doctor.

Copies of these x-rays will be provided at your expense (payment in advance) upon reasonable time notification to our office.

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.

Signature of Patient/Guardian

Date