

## **Financial Policy**

Thank you for choosing Edison Foot and Ankle Care as your foot care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. Below is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

**\*FULL PAYMENT IS DUE AT TIME OF SERVICE FOR NON-PARTICIPATING PRIVATE INSURANCES AND SELF PAY.**

**\*WE ACCEPT CASH, CHECKS, AMEX, VISA AND MASTERCARD.**

**Regarding Insurance Plans where we are a participating provider:** All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to paragraph below.

### *Regarding Private Insurance and Non-Covered Services*

We do require full payment at time of service for Insurance Companies we are not participating with. If you have Insurance that our doctors are not Providers of, this is a contract between you and your insurance company. We are not a party to that contract. You may request a receipt for submission to your insurance company, or as a courtesy to you, we will submit a claim form on your behalf to your insurance company for any out of pocket expenses that have occurred.

### *Usual and Customary Rates*

Our practice is committed to providing the best treatment for our patients and we charge usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

### *Adult Patients*

Adult patients are responsible for full payment at time of service.

### *Minor Patients*

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, cash or check.

### *Missed Appointments*

There is a **\$30** charge for a broken appointment without **24 hour** notification.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Responsible Party

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Co-Responsible Party