PAYMENT POLICY FOR RAMOS FOOT AND ANKLE CENTER, LLC

Payment Policy

Thank you for choosing Ramos Foot and Ankle Center, LLC as your foot care provider. We are committed to providing you with quality affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Insurance: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-Covered Services: Please be aware that some and perhaps all of the services you receive may be uncovered or not considered reasonable or necessary by your insurance. You must pay these services in full at the time of visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof or insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Non-Payment: Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If you account is over 60 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we will refer your account to a Collection Agency and you and your immediate family will be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative Podiatric care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Balances: If your insurance has a deductible or co-insurance and you have a balance at the time of your follow up appointment you are required to pay your balance in full at the time of that appointment. If you cannot pay for your balance at that time we will reschedule your appointment for a

later date when you are able to do so.

Missed Appointments: Our policy is to charge $25.00 for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Fees: Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our Payment Policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date