

**2017 MIDWAY FOOT & ANKLE CLINIC FINANCIAL POLICY**  
**www.midwayfootandankle.com**  
**ANDREW SOO, DPM**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

**PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS OR CREDIT CARDS. OTHER ARRANGEMENTS MUST BE MADE WITH OUR OFFICE MANAGER PRIOR TO TREATMENT.**

**IT IS OUR POLICY THAT ALL OUTSTANDING ACCOUNTS MUST BE PAID WITHIN A 30-DAY PERIOD. ALL ACCOUNTS NOT PAID WITHIN THAT TIME FRAME WILL HAVE A \$10.00 SERVICE FEE ADDED PER MONTH.**

**NSF fee of \$30.00 will be assessed to all returned checks.**

**Regarding X-Rays:**

X-Rays that are taken by our office are available for copy to CD. Please ask at the front desk. One CD will be copied at no charge and there will be a charge of \$5.00 for each additional copy.

**REGARDING INSURANCE:**

**We require any copays or deductibles at time of service.** We cannot bill your insurance company unless you give us a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. **In the event that your insurance company does not pay or pay in full you are responsible. You may contact your insurance company but this should not delay your payment.**

Please be aware that some and perhaps all of the services provided may be non-covered and not considered reasonable and customary under the Medicare Program and / or other medical insurance, in which case you are responsible for payment.

**PERSONAL OR WORK RELATED FORMS FILLED OUT BY THE DOCTOR:**

All forms requiring sections to be completed by the doctor are usually not payable by the insurance companies or your employer. All forms to be filled out by the doctor will have a charge of \$25.00 payable prior to completion.

**REFERRAL POLICY:**

All patients with insurance companies requiring referrals must have a valid referral **on the day of service** to be seen. If referral is not obtained, patient will be responsible for obtaining the referral and/or payment of services rendered.

**USUAL AND CUSTOMARY RATES:**

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

**MINOR PATIENTS AND/OR DISABLED PATIENTS:**

The adult accompanying a minor and the parents (or guardian(s) of the minor) are responsible for full payment. Parent and or guardian must accompany all minors and developmentally delayed patients, unless prior arrangements have been made. We will bill only the parent who brings the child in regardless of court orders, and payment will be the responsibility of this parent.

**MISSED APPOINTMENTS**

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

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

I have read the Financial Policy. I understand and agree to this Financial Policy.

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