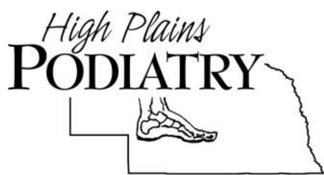

Robert C. Hinze, D.P.M.

Patient Name: ______________________________

Patient DOB: ______________________________

Responsible Party: ______________________________

Responsible Party DOB: ______________________________

Financial Policy

Thank you for choosing High Plains Podiatry PC for your foot care needs! The following is a statement of our FINANCIAL POLICY. ALL patients must accept our FINANCIAL POLICY before receiving treatment.

Please understand that full payment of your bill is considered part of your treatment.

METHOD OF PAYMENT: We accept cash, checks, VISA, MASTERCARD and CARE CREDIT. Payment plan may be arranged on an individual basis with the Office Manager.

INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of your claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network, with your insurance company. We cannot bill your insurance company unless you give us your complete insurance information. If your insurance information is not received prior to treatment, then payment is due in full. It is your responsibility to verify the benefits covered by your plan as the insurance company may not cover all of the services provided to you. If your insurance company has paid its portion of your account, then any balance left will become your responsibility to pay in full by the statement due date.

Definitions:

Co-payment: A fixed dollar amount set by your insurance contract that is to be paid at the time of an office visit. This amount is usually between $15 and $50.

Deductible: An annual dollar amount established by your insurance plan that is deducted from your insurance benefits. This amount is your obligation and must be paid prior to health care services.

Co-insurance: A percent set by your insurance plan that is deducted from your insurance benefits. This percent usually ranges between 10% to 30% and is your obligation to pay.

ALL COPAYS, DEDUCTIBLES AND CO-INSURANCE REQUIRED BY YOUR INSURANCE COMPANY ARE DUE PRIOR TO TREATMENT.

LATE FEE: A late fee of $20 will be added to any accounts that are 60 days past due and have no payment activity.

MISSED APPOINTMENTS: Please notify our office at least three (3) hours in advance if you cannot make your appointment. We reserve the right to discharge you from our practice if you have three(3) no-shows for scheduled appointments.

RETURNED CHECKS: A $25 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay in full by cash, Visa or Mastercard.

COLLECTIONS: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible.

I have read the above financial policy and agree to its terms.

Patient/Guarantor Signature ______________________ Date __________

10/09/13