

PAYMENT POLICY

Thank you for choosing West Georgia Podiatry as your foot care provider. We are committed to providing you with quality and 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.

1. **Insurance:** We participate in most insurance plans, including Medicare. 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 a current insurance card, payment will be 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.
2. **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 at each visit.
3. **Non-covered services:** Please be aware that some of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to verify insurance coverage. 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. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then.
5. **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.
6. **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.
7. **Nonpayment:** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. A \$10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will only be accepted if prior-approved by our billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. In the event this happens, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments:** It is our policy to call you and confirm your scheduled appointment. There will be a \$25.00 charge 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.
9. **Forms and Documents:** It is our policy to charge \$15.00 for completion of all forms, such as disability applications, etc.
10. **Fees:** Our fees are representative of the usual and customary charges for specialists in our area.

Thank you for understanding our payment policy. Please let us know if you have any questions.

I have read and understand the payment policy and agree to abide by these guidelines.

Signature of patient (or responsible party)

Date