PATIENT FINANCIAL POLICY

If you have any questions regarding our financial policies, please discuss them with our front office staff or office administrator.

- As our patient, you are responsible for all **authorizations/referrals** needed to seek treatment in this office.
- All **co-pays** and **deductibles** are due at the time of service. We accept Visa, MasterCard, Discover, American Express, Care Credit, checks and cash.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, **we will file your insurance claim.** We will attempt to verify benefits for routine and specialized services. We can only **quote** benefits given by your insurance company. **We cannot guarantee payment.** In the event your insurance company does not cover a service or item, you will remain responsible for any services rendered.
- It is your responsibility to notify us of any **insurance changes**. In the event this office is not informed, you will be responsible for any charges denied.
- There are procedures for which we require **pre-payment.** You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the date of service.
- Statements will be mailed monthly, and payment is due upon receipt.
- A **$25.00 billing fee** will be charged if you cannot pay your co-pay or any other fees due at the time of service.
- A **$50.00 fee** will be charged if you **do not show** for your appointment. However, if you call and **reschedule** or **cancel** your appointment this fee will not apply. Excessive abuse of scheduled appointments may result in discharge from the practice.
- **A $25.00 fee** will be charges if you reschedule or cancel your appointment less then 24 hours of your appointment.
- There will be a fee for all FMLA, Aflac, Disability and more paperwork that is required to be filled out.
- A **$30.00 service fee** will be charged for all **returned checks.**
- By signing this form, I give **Montgomery Foot Care Specialists, PC** and its employees and or agents “express prior consent” to contact me at any/all phone numbers, including cell phone numbers (by phone or text message, which could result in charges for you) for the purpose of treatment, insurance, or payment. We may contact you by email, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of automatic dialing device, as applicable.
- **Past due** accounts are subject to **collection proceedings.** All costs including, but not limited to; **collection agency fees** (33.33%)**, attorney fees** and **court costs** shall be your responsibility in addition to the original balance. By signing this form, I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

Signature of Patient/Responsible Party:_____Date:_____

Print Name of Patient/Responsible Party: _____