

AllCare Foot & Ankle Center, PA

Michael V. Tran, DPM

Office and Financial Policies

First of all, we would like to welcome you to our office. To reduce confusion and misunderstanding between our patients and practice, we have adopted the following policies. If you have any questions regarding these policies, please discuss them with our Account manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

INSURANCE: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment/co-insurance at the time of service. This office's policy is to collect this co-payment/co-insurance when you arrive for your appointment

HMO: The co-payment made at the front desk is for the visit only and often considered the time you spend with the physician. If an HMO patient follows the **referral or authorization guideline** before their visit to a specialist, medical necessity and service is a covered service as determined by your insurance company.

All other Insurances: The co-payment made at the front desk is for the visit only often considered the time you spent with the physician. If you have any procedures performed during your visit to AllCare Foot & Ankle Center, the procedure co-payment, deductible and or co-insurance (most-likely) is not covered in the co-payment made at the front desk. Unless otherwise stated by your insurance company, all other insurances have **-CO-PAYMENTS & OR CO-INSURANCE, ENCOUNTER FEES, YEARLY DEDUCTIBLES, MUST MEET MEDICAL NECESSITY AND BE A COVERED SERVICE.** *In other words, the amount you pay during your visit may not be all you owe. Your final responsibility will be determined after your insurance company has received a bill for all services rendered, process and paid your claim.*

PRIVATE PAY PATIENTS: As a private pay patient you will be asked to make a deposit prior to seeing the doctor. It is very important that you ask about the cost of care or services that your physician is recommending prior to the service being performed. At the end of my visit, I understand that I will receive a refund or expected to pay for additional charges.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Miscellaneous:

- You acknowledge that the insurance card and information provided each visit is the correct and current information. You understand that it is your responsibility to inform the AllCare Foot & Ankle Center, PA if a change in your insurance coverage occurs
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. **SERVICES MOST OFTEN DENIED BY INSURANCE COMPANIES: Orthotics and Routine Foot Care** for patients who do not meet "medically necessary" criteria. Please call your insurance company to verify coverage of these services. The customer service number is located on your card. We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office. You understand that should the AllCare Foot & Ankle Center physician visit you in the hospital or perform surgery, that these physician fees are separate than surgical assists, hospital, anesthesia, lab or pathology fees.

****Please contact the office 24 hours in advance if you need to Cancel or Reschedule an appointment****

Finance Charges

After your insurance claim is processed, you will have 30 (Thirty) days to pay any unpaid balance. If your account becomes 30 days past due, the remaining balance will be subject to a **12% monthly finance charge**. We will attempt to collect any unpaid balance, however, if we are unsuccessful an outside collection company may be used.. All checks returned as "NSF" or "insufficient funds" or "account closed" will be charged \$35.00. Please keep your account current. If you need to make financial arrangements with our office, we will be try our best to assist you.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **AllCare Foot & Ankle Center, PA or Dr. Michael V. Tran** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Signature of Patient/ Responsible Party if Minor: _____

Consent for Treatment:

I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures and or treatments prescribed by my physician, his/her assistants or designee as is necessary in his/her judgment.

Signature of Patient/ Responsible Party if Minor: _____

Notice of Patient Privacy Protection:

I acknowledge that I have received the Notice of Privacy Practices and have had the opportunity to review it.

Signature of Patient/ Responsible Party if Minor: _____

Authorization to Release Information

I hereby authorize **AllCare Foot & Ankle Center, PA** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **AllCare Foot & Ankle Center, PA** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. In the event of default, I understand that the AllCare Foot & Ankle Center may use an outside collection company and or report returned checks to the Attorney General office for the State Of Texas.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I understand that our records contain protected health information about you and as such are highly confidential. When appropriate, this office may use medical records for non-treatment purposes (research, public health, and some operational activities).

I have read and understand the office and financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Patient / Responsible Party if a Minor: _____ Date: _____

Relationship to Patient _____