Dr. Thomas M. Herrmann
Dr. Steven W. Kreamer
Dr. Peter J. Fodor
Dr. Melissa A. Cavallaro

Podiatric Medicine, Sports Medicine, Foot & Ankle Surgery

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or manager.

- **As our patient, you are responsible for all authorizations/referrals needed to seek treatment.**
- **Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, Mastercard, Discover, cash or check.**
- **Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if we are a participating provider with your insurance carrier. If your insurance carrier does not pay the practice within a reasonable period, we will have to look to you for payment.**
- **We have agreements with the major insurance carriers in the area and will accept assignment of benefits. We will bill those plans and will require you to pay the co-pay/co-insurance or deductibles at time of service.**
- **If you have insurance coverage with a plan or carrier that we do not have a prior agreement, we will ask for payment at time of service and provide a detailed receipt to you to file with your insurance carrier. Your insurance carrier in turn will reimburse you directly.**
- **All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans directly for clarification of benefits prior to services rendered.**
- **You must inform the office of all insurance changes and authorization referral requirements. In the event that the office is not informed, you will be responsible for any charges denied.**
- **For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.**
- **There are certain elective services and supplies that we require pre-payment. You will be informed in advance if your procedure is one of these.**
- **Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees shall become your responsibility in addition to the balance due this office.**
- **There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.**
- **All appointments require a 24 hour notice of cancellation. Failure to give a 24 hour notice or no showing for an appointment may result in a fee.**

Patient/Responsible Party Signature:____

Printed:______________________________________ **Date:**_____________