Las Cruces Family Foot & Ankle

FINANCIAL POLICY

INSURANCE: If you are not insured by a plan we participate in you are responsible for out of network rates. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. **We do participate in several PPOs, Medicare, and Medicaid programs, however; it is the responsibility of the patient to verify if we are In-Network providers with their insurance company. New patients' insurance cannot be filed unless we receive a copy of the insurance card and driver's license on the first visit. In addition, it is the patient's responsibility to manage referrals/authorizations if required by his/her insurance carrier**.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductible must be paid at the time of service. If you do not have your co-payment at the time of your service, you will be charged a $10 processing fee. 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.

SELF PAY/CASH PAY: Payment in full is due at the time of service and we accept the following payment methods: Cash, Check, VISA/MasterCard/American Express/Discover, and Debit Card. Hardship program is offered to those who qualify; a 20% discount is taken if payment in full is made the day of service.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. **You are responsible for payment of these services.**

WORKERS COMPENSATION: This office is a certified New Mexico Bureau of Worker's Compensation and accepts approved claims. Any Dissallowed Claim fees will be the patient's responsibility.

BILLING SERVICE:
Advanced Medical Billing Consulting will be processing all claims and sending statements. Please phone our billing service at **575.449.7005** for any questions concerning your statement balances and payments made on your account. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

DELINQUENT ACCOUNTS/COLLECTIONS: Account balances over 90 days will be sent to collections after no response from the patient. Statements will be mailed once per month for three months before becoming delinquent. **It is the patient's responsibility to inform the staff of any changes in address or insurance information.**

ADMINISTRATIVE SERVICE FEES: It is our office policy that we require administration fees to be paid before the completion of any FMLA, Disability, Patient Assistance, or Unemployment forms. Fees will vary per form and will cover a single diagnosis per global period.

NO-SHOW POLICY: We understand there are times when you must miss an appointment due to an emergency. However, when you fail to cancel after your second no-show you will be charged a $25 fee; this will not be covered by your insurance company.

I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I acknowledge and accept this Financial Policy
I have read the above policy regarding my *financial responsibility* to **M. Douglas Sefcik, DPM LLC** for medical services provided. I agree to pay **M. Douglas Sefcik, DPM LLC** any balance unpaid by my insurance carrier for myself or the below named person. I understand that I will be responsible for balances if insurance has not responded in 90 days.

ASSIGNMENT OF BENEFITS:
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Las Cruces Family Foot & Ankle,** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care.

Signature: _____

PRINT Patient Name: _____

Relationship to Patient: _____

Date: _____