Coastal Podiatry Associates

Patient Financial Policy

Thank you for choosing our practice for your Podiatric needs. We are committed to providing you with the best possible medical care. Please understand payment of your bill is considered a part of your treatment. The following is a statement of our financial Policy, which we require you read and sign prior to any treatment.

- Payment for all services provided by our practice is due in full at the time services are rendered. Exclusion to this policy are those patients who are members of a managed care plan with which our practice participates.
- If we participate with your insurance plan, co-payments and any unmet deductible amounts will be required at the time you register. We will verify your insurance benefits at the time of service.
- If our practice does not have a contractual agreement with your insurance plan, you are responsible for the full payment at the time service are rendered.
- All patients are responsible for any non-covered services and will be asked to sign an Advanced Beneficiary Notice (ABN) for any non-covered services or supplies prior to the service. You will be responsible for your deductible, co-pays, and any service deemed medically unnecessary and all non-covered services or supplies.
- This practice will not file any secondary insurance to Medicare unless it is an e-crossover from Medicare, or a plan in which we participate. In this case, Medicare patients will be responsible for their co-payments and/or deductibles.
- This practice accepts Cash, Personal checks, MasterCard, and Visa as payment for services.
- A $30 Return Check Fee will be assessed to your account for every check returned to this practice. No checks will be redeposited.
- Some plans require prior authorization from you primary care provider in order for our physicians to see you and receive payment from your insurance plan. While we make every effort to obtain this prior to the date of service, if we do not have this authorization number, we may need to reschedule your appointment. The member is ultimately responsible for the authorization, not our office nor the Primary Care Provider.
- If you are scheduled to have a procedure/surgery performed, we will conduct a pre-operative benefits check with your primary insurance company to determine as accurately as possible what your patient responsible amount will be after insurance pays. Payment is expected prior to the procedure being performed.
- Refunds will be issued (when applicable) on a monthly basis. Refunds will be given in the form of a check.
- If you do not give us 24 hours notice of an appointment cancellation, you may be subject to $25 cancellation fee.
- If you do not have insurance or for services not covered by insurance, the practice requires payment of 100% of the total charges. Please speak with our Office Manager if you have any questions or if you need information regarding our practice's self pay policies.
- It is our policy to send to the patient three consecutive monthly statements with any balance owed to the practice by the patient. Once all attempts at collections are exhausted, the patient's account is then placed with an outside collection agency with management's approval. After that time, the patients agrees to pay the cost of collection including reasonable attorney's fee, if this account should be place in the hands of an attorney for collections.
- We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in making payment arrangements.
- If you have any questions regarding our financial policies, please feel free to speak with our Financial Counselor or Office Manager. We will make every effort available to you to clarify any misunderstanding you have regarding your account.

PLEASE READ THE ABOVE INFORMATION CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read, understand, and agree to the terms of this policy. I also request that payment of authorized benefits be made to Coastal Podiatry Associates. I authorize them to release medical information to my Insurance plan and its agents any information needed to determine these benefits or the benefits payable to related service. The undersigned certifies that they are either the patient, or is duly authorized by the patient's general agent to execute the above and accept the terms.

Patient or Representative Signature:_____ Date: _____