FOOT CENTER McALLEN WESLACO PLLC
FINANCIAL POLICY

Welcome and thank you for choosing Foot Center McAllen Weslaco PLLC (FCMW or Practice). We feel we can better serve your healthcare needs if you are familiar with the following policies and procedures.

OFFICE HOURS: Our offices, McAllen and Weslaco, are open Monday through Friday from 8:00am to 5:00pm. Providers are available on an emergency basis at any time.

APPOINTMENTS: Appointments may be made by phone during office hours or requested through our website. Every effort will be made to provide the earliest possible attention for the convenience of the patient. Patients new to our Practice are requested to arrive 15 minutes before their scheduled appointment for the registration process. Due to the unscheduled nature of emergencies, occasional delays do occur. We hope that you will understand that these delays are unavoidable. If you are unable to keep your appointment, please call us to cancel as far in advance as possible.

ALL PATIENTS ARE REQUIRED TO READ AND SIGN A COPY OF THIS POLICY, WHICH IS TO BE RETAINED IN THE PATIENT'S MEDICAL RECORD.

1. To protect your medical identity, we ask that you present your insurance card(s) and a photo ID at each visit. It is your responsibility to provide us with the correct information to ensure proper billing to your insurance company(ies).
2. If you have a change of address, telephone numbers, and/or employer, please notify the front desk and we will be happy to update your records. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information.
3. It is our policy to collect payment at the time of services. We will collect your deductible, co-pay, co-insurance, or charges for non-covered services at the time of your visit (based on the allowed amount from your insurance). We accept cash, check and/or credit card (with proper ID). Returned checks will incur a $30.00 fee. Credit card chargebacks will incur a $40.00 fee. Replacement of lost refund checks will incur a $40 fee to cover stop payment of lost check.
4. If your insurance company does not cover a service or denies a charge, you will be billed for the entire balance, subject to the requirements and limitations of your insurance company. You will be expected to pay your balance in full within ten (10) days or call our billing department to make payment arrangement. If payment is not received within 90 (ninety) days, your account will be subject to collection proceedings.
5. If your insurance company requires a referral and/or prior authorization, it is your responsibility to obtain this from your primary care provider or insurance company prior to your appointment. We will be happy to assist you with this process.
6. We participate with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan.
7. In accidents, legal cases, etc. in which an insurance company or other party is presumed liable for your expenses incurred as a result of your accident or illness, FCMW looks to the party receiving the services for payment and cannot be expected to wait for the conclusion of long-term court cases or the settlement of disputed insurance claims before being paid. The party receiving such services is expected to take care of his/her account in line with the above credit guidelines.

INDEMNITY NSURANCE CLAIMS: If you have indemnity insurance, which will pay for services rendered at FCMW, it is our policy to provide to you, without charge, a statement with all the information needed by your insurance company. You should forward this statement together with your insurance claim form, filling out the patient part only, directly to your insurance company. It must be understood, however, that financial responsibility for the account rests with the patient. Insurance claims on services performed must be requested by the patient. You will be responsible for any deductible at time of service.

*Caution: If your insurance covers services rendered at FCMW, it is your responsibility to request an itemized statement from our office covering these services. If you have filed an insurance claim and no payment or rejection notice has been received within 60 days from the date of filing, we encourage you to:

1. Contact your insurance company as to the reason for delay
2. Make regular payments on your account to keep it in good standing. Any overpayment will be refunded in the event the insurance pays directly to FCMW.

MEDICARE PATIENTS: FCMW is a participating provider with Medicare Part B and we will bill Medicare for all your covered charges. If you have a supplemental carrier, we will also bill that for you. If payment is not received from your

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supplemental carrier within forty-five (45) days of being submitted, we will bill you for the balance due on the Medicare Allowable. IF YOU DO NOT HAVE A SUPPLEMENTAL CARRIER, THE 20% MEDICARE DOES NOT PAY WILL BE COLLECTED FROM YOU AT THE TIME OF YOUR VISIT. Each year, you will be expected to pay the allowed amount of your charges until your annual Medicare deductible has been met.

SELF-PAY PATIENTS: Patients without medical coverage will be expected to pay in full at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements.

PAST DUE AMOUNTS AND COLLECTION POLICY: It has become increasingly difficult for us to collect fees. We have found it helpful to be explicit in our Financial Policy. All too often, patients state that they have no form of payment. We ask that you please come to your appointments with some form of payment to meet your financial obligations.

1. Accounts over thirty (30) days with no payment activity or no arrangements for payment will be placed on Collections Status and will be turned over to an independent agency for additional collection.
2. If your account is in Collection Status: you may be required to pay the personal balance in full prior to your next visit, and all future services will be on a CASH BASIS or automatically charged to your credit card.

DIVORCED PARENTS OF MINOR PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

FORM FEES: There is a $15.00 fee to complete forms. The forms may include, but not limited to: disability, FMLA, loan, supplemental insurance policy, daycare forms, etc. Payments must be made prior to the completion of the forms. The office will have 10 business days in which to complete forms before making them available for patient to pick up.

COPIES OF MEDICAL RECORDS: Paper copies will incur a a $25 fee for the first 20 pages, and 50 cents for each page thereafter. X-ray copies will incur an $8 fee per copy plus cost of mailing, shipping, or delivery if needed. For records provided in an electronic format, a $25 fee applies for 500 pages or less and $50 for more than 500 pages. A reasonable fee for the actual cost of supplies, and postage (if applicable) will be applied. If an affidavit is requested certifying that the information is a true and correct copy of the records, a $15 fee will apply.

COMPLAINTS: It is our sincerest desire that you will have no occasion to register a concern, but if that occasion should arise, please call any of the providers or the office manager at (956) 682-4187. Your constructive criticism is encouraged at any time to assist us in improving service to our patients.

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, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to Foot Center McAllen Weslaco PLLC for medical services to myself and/or my dependents regardless of my insurance benefits, if any.

Please remember, whether you have medical insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our Financial Policy, please contact our billing department.

I have read and understand the foregoing Financial Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the Practice from time to time.

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Printed Patient's Name **Date**

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Patient's Signature (or Guarantor, if applicable)