Total Footcare, P.C.

Full Payment is expected at the time of service unless other arrangements have been made previously.
We accept Cash, Check, MasterCard and Visa.

A 24-hour cancellation notice is expected if you cannot make your appointment. If you Do Not call and cancel the appointment a $25 fee will be billed for the missed appointment.

PRIVATE INSURANCE
Your insurance policy is a contract between **you and your insurance carrier**. We are not a party to that contract. If your policy deems a particular service as non-covered, it is up to you to discuss with them why it is not covered. We do not alter treatment here based on what your insurance policy covers or does not cover. This office will file primary insurance claims with your insurance company. ***It will be the patient's responsibility to file all secondary insurance claims.*** Your bill with the physician is your responsibility regardless of primary or secondary insurance payments. ***It is the responsibility of the patient to provide the office with current information.***

UCR (Usual and Customary Reimbursement)
We have taken great care in determining our fees. Please be assured that our charges accurately reflect the level of skill, complexity and expertise for this geographical area. If your insurance company's fee schedule falls below the level of our charge, you will be responsible for the difference. (Unless we have a written contract with your insurance company).

MEDICARE PATIENTS (if applicable)
We are participating physicians with Medicare. This means that you will be responsible for your 20% of the approved Medicare fee, yearly deductible amounts, and payment in full for any non-covered services. **Non-covered services include services that Medicare deems *not medically necessary.***

MINOR PATIENTS (under 18)
Parent or guardian must accompany minors or have written consent for treatment of minor. Charges may be pre-authorized to Visa/MasterCard or payment by cash or check may be made at the time of service.

MANAGED CARE CONTRACTS
We are currently participating in "Managed Care" (PPO, HMO, PHO) programs. ***It is your responsibility to make sure that you have referrals on file from your primary care physicians.*** You will be responsible for all co-pays, deductibles, non-covered services and payment for treatment on the days no referrals are on file.

WORKERS COMPENSATION
We acquire authorization from your employer for all workmen's compensation claims. We will file all claims with your company's workmen's compensation carrier. In the event that the compensation is disputed you will be responsible for payment in full.

RETURNED CHECKS
A service fee of $30.00 will be assessed to **each** returned check.

DUPLICATION OF MEDICAL RECORDS
A duplication fee will be charged for an amount allowed by Virginia state law. A $10 dollar search and retrieval fee, .50 cents a page up to 50 pages then .25 cents thereafter. Original x-rays will not be given to the patient. They are property of Total Footcare. They can be copied for $40 an x-ray sheet.

IF YOU HAVE ANY QUESTIONS PERTAINING TO WHETHER OR NOT WE ARE A PROVIDER FOR YOUR INSURANCE COMPANY, PLEASE SEE THE FINANCE MANAGER.
I hereby authorize the physicians of Total Footcare, P.C. and their designated assistants to administer such treatment as is necessary and to perform additional procedures as considered therapeutically and/or diagnostically necessary. I authorize the release to my insurance company any medical information regarding my claim for benefits and request payments of benefits directly to the attending physician. I understand that I am financially responsible for all charges arising for the treatment of myself (or the above name patient). I agree to pay a FINANCE CHARGE OF 2% PER MONTH on balances over thirty (30) days past due, which is an Annual Percentage Rate of 24%. If this contract is referred to an attorney for collection, I agree to pay all court costs, including attorney's fees in the amount of twenty-five percent (25%) of the total indebtedness then due. I also agree to appear in court at the county courthouse that the case is filed.

I have read and understand my financial responsibilities under this policy.

Patient/Parent Signature_____Date_____