

**Patient's Financial Agreement:**     Methuen Podiatry Associates L.L.P.

Our practice philosophy is that the doctor-patient relationship is a partnership in which our common goal is working towards your health and wellness. As a partner in your care, it is important for you to understand your insurance benefits and financial obligations. Your insurance policy is an arrangement between you and your insurance company. This is not something which we have any influence over.

**Check In:** It is your responsibility to provide our office with a current and valid Insurance Identification card.

You must know your insurance. If you present with an **incorrect** Insurance card, or do not have the primary insurance cards, billing could be sent to the wrong insurance. If the insurance payer pays your charges and then retracts payments for other insurance, the patient will be responsible for the bill. All billing must be done within 60 days from the day of service. Any delays caused by incorrect insurance information will result in you being responsible for the entire cost of the visit.

If you do not have your insurance card available, you will need to pay for the visit at the time of the service, or we will reschedule your appointment. We will also **collect your copayment, outstanding balances, and payment for any services that are not covered by your insurance.**

**Uninsured Patients:** Patients without insurance will be asked to pay for services at the time of the visit.

The cost of a new patient examination is dependent on the complexity of the condition. Procedures carry an additional fee. Please call the office if you need an estimate.

**Referrals:** It is your responsibility to know if your Insurance plan requires a written referral and to obtain one from your primary care provider. Payment will be collected the same day of the visit if no referral is on file.

**Check Out:** Payment for Non-Covered services and for any dispensed medical supplies is due at the time of checkout. Payment for services not covered by insurance, ex. Palliative nail care, Corns, Calluses is also due.

**Outstanding Balances:** Patient balances are billed upon receipt of your insurance plan's explanation of benefits. Billing is then mailed to you and payment is expected within 30 days. If payment is not received within thirty days, a repeat billing fee of \$6 will be assessed. If the account must be turned over to a collection company, a \$35.00 collection fee may be assessed.

Bounced checks will incur a service fee of \$20.00 plus \$12.00 fee assigned by the bank totaling \$32.00 added onto your account in this event.

By signing below, I agree to accept full financial responsibility as a patient (or responsible party for a minor patient under the age of 18). I have read, understand, and agree with each of the terms listed above and will comply with fulfilling financial and legal responsibility to pay for services.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient/Guardian

\_\_\_\_\_  
PRINT NAME of Individual responsible for Payment

\_\_\_\_\_  
Date

DISCLOSURE STATEMENT MUST BE SIGNED