UNIVERSITY PODIATRY ASSOCIATES

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that 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. All patients must complete our information and Insurance form before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD AND DISCOVER/AMERICAN EXPRESS.

Regarding Insurance:

We will accept assignment of insurance benefits for those plans we contract with. However, we do require copays and deductibles be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not yet paid your account in full within 45 days, the balance will be billed to you. For your convenience, we can bill these balances to your credit card. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Regarding Insurance Plans where we are participating provider. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary

Adult Patients:

Adult Patients are responsible for full payment at time of service.

Minor Patients:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, Visa, Master Card, and Discover/American Express, or payment by cash or check at time of service has been verified.

Missed Appointments:

Unless canceled, at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Interest:

We reserve the right to charge interest in the amount of 1.5% per month as provided by state law on unpaid balances. Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____
Date_____
Signature of Patient or Responsible Party
X_____
Date_____
Signature of Co-Responsible Party