PATIENT FINANCIAL POLICY

Advanced Foot and Ankle of WI, LLC

Thank you for choosing Advanced Foot and Ankle of WI for your care. We will provide medical services to you provided that you understand and comply with the following financial policies of our practice. If you have any questions about the following, please ask to speak with one of our billing staff or office manager.

SUBMISSION OF INSURANCE CLAIMS

YOUR HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR HEALTH INSURANCE PLAN. You are responsible for understanding and following your health plan's required procedures and policies. It is your responsibility to provide us with accurate and up-to-date insurance information, so that we can file an insurance claim on your behalf for services rendered. If we do not receive payment within 60 days from the date the claim is filed with your health plan, you are responsible for the unpaid balance and we may request immediate payment from you. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. It is your responsibility to contact your health plan regarding benefits or coverage issues.

REFERRALS AND PRIOR AUTHORIZATIONS

If your health plan requires you to have a referral authorization from your primary care physician in order to be seen by our practice, it is your responsibility to verify that a referral has been received by our office prior to your visit. FAILURE TO HAVE A VALID REFERRAL AUTHORIZATION MAY RESULT IN YOUR APPOINTMENT BEING RESCHEDULED UNTIL A VALID REFERRAL IS OBTAINED. If you request to be seen without a valid referral, you will be responsible for payment of services rendered and will need to complete additional paperwork that will allow us to bill you for services rendered. If your health plan requires surgery pre-authorization, please notify your provider of this provision. Our billing office will assist you in pre-authorization of your surgery. During the pre-authorization process, your health plan and your employer may be contacted to verify plan enrollment. Pre-Authorization does not guarantee payment of your surgery costs. Failure to have your surgery pre-authorized if required by your health plan may result in denial of medical payment for services rendered. If payment is denied, you may be responsible for payment of the balance in full. If you have any questions about your benefits or what services are covered under your health plan, it is your responsibility to contact your health plan prior to surgery.

CO-PAYMENTS AND NON-COVERED SERVICES

If your health plan required a co-payment, we are required to collect it at the time of your visit. We cannot waive co-payments, deductibles or co-insurance amounts, which are the patient's responsibility. Co-payments and non-covered services are collectable at the time of your visit. If you cannot make the required payment, your appointment may be rescheduled. If you do not have health insurance coverage or request a services that is not covered by your health plan (i.e., cosmetic in nature) we require that payment be made in full at the time that services are rendered. For your convenience, we accept cash, personal or cashier's check, VISA, MasterCard or Discover Card payments.

PATIENT RESPONSIBILITY FOR BILLED AMOUNTS

We will send you a statement of any remaining balance on your account after health plan payments are applied. Payment is due in full within 30 days from the date that appears on your billing statement. If you cannot make payment in full, you will need to contact our billing department to arrange a payment plan. If we do not receive payment from you within 60 days from the date of the first billing notice, we will attempt to contact you for a payment. If we receive no further response within the next 30 days, your account may be turned over to our collection agency. IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND LEGAL FEES INCURRED.

MINORS

A parent or legal guardian must accompany a minor and consent to treatment. Parents or legal guardians must comply with the terms of this financial policy. The parent or legal guardian that accompanies the minor will be held responsible for payment of services.

MISSING, INACCURATE OR INCOMPLETE BILLING INFORMATION

You are responsible for notifying our office of any health plan or billing information changes. Failure to notify us of changes may result in your being responsible for any remaining balance on your account. Our practice will not be responsible for any billing errors, lack of coverage or payment due as a result of missing, inaccurate or incomplete information that you provided us, including inaccurate information on secondary or third party payment coverage.

I have read and understand the *Patient Financial Policy* for Advanced Foot and Ankle of WI, LLC and accept all the terms and conditions as stated above. I have received a copy of this policy.

_____ _____

Signature of Patient Date

_____ _____

Signature of Minor patient's parent or legal guardian Relationship to patient