



**R.A. Cooper, D.P.M., M.A.**  
**Diplomate, ACCPPS**  
**Board Certified in Foot Surgery**  
**Dr. Anna L. Ballard, D.P.M.**

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## Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. This is our FINANCIAL POLICY that is strictly enforced. If you cannot abide by this policy, or if you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash, debit or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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," or you do not have an authorization, you will be responsible for payment. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. As a courtesy to you, we will gladly check your benefits and complete prior authorizations when needed. Any benefits or prior authorizations quoted to you are estimated and never guaranteed as the insurance company makes the final decision on your claim.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- If you do not have medical insurance, we offer a discounted fee to you. We require you pay \$60.00 cash or credit card upon arrival at our office BEFORE you see the podiatrist. We also require a payment minimum of 50% of the remainder charges of your office visit AT THE TIME OF SERVICE. The remainder 50% balance must be either paid in full or remaining balance set up on a payment plan before leaving the office by our billing representative.
- For patients 17 years and younger, a parent or guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors).
- The adult accompanying a minor is **fully responsible for full payment of medical services** including co-payments, coinsurances, deductibles, and non-covered services. The legal agreement for child support and payment of medical services is between the judge, the mother and the father-NOT your physician.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$32.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: \_\_\_\_\_

Printed Name of Responsible Party: \_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_