



SOUTH SHORE PODIATRY ASSOCIATES

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FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is due, in full, at time of service, unless you have made other financial arrangements, in advance, with our business office. If you have insurance coverage with one of the plans we participate with, we will bill your insurance company along the guidelines of our contract. However, we require that **ALL CO-PAYS OR DEDUCTIBLES** be paid at the time of service. If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you any amount due. As a courtesy to our patients, we will submit a claim to your insurance company. We accept Cash, Check, Mastercard, Visa, Discover or American Express. Returned checks will be subject to an additional \$25 service fee.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize, however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. While the filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered. **The patients is responsible for filing claims with secondary insurance companies.**

We do participate with Medicare and Medicaid and are preferred providers for the following plans:

Aetna (all plans)	Beechstreet	Blue Cross/Blue Shield (all plans)
Cigna (PPO, Open Access Plus)	HealthSmart	PHCS
United Health Care	Unicare	

You will be required to show a copy of your insurance card and driver's license at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day.

Our time, as is yours, is very valuable and if for some reason you cannot make your scheduled appointment, please be kind and call us at least 24 hours in advance. If you fail to show for your appointment, your account will be assessed \$25.

If you have questions regarding this information, please do not hesitate to ask us. We are here to help you.

I hereby understand the financial policy set forth by South Shore Podiatry Associates. I guarantee payment of all charges incurred for the account of the patient below. I further agree to pay any attorney's fee, court costs and related collection fees incurred.

Print Name: _____ **Date:** _____

Responsible Party Signature: _____

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