GREATER TEXAS FOOT & ANKLE SPECIALISTS

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. **Please inform us at every visit of any changes to your insurance coverage.**

Please initial each line indicating your understanding of our policies:

____ **COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

____ **DEDUCTIBLES, OOP & CO-INSURANCE:** If you have a high deductible plan (Remaining amount greater than $250.00) OR a plan with no deductible and high out of pocket (remaining amount greater than $250.00), we may collect a $125 deposit to apply towards your deductible and coinsurance. Any remaining balance after submission to your insurance company is your responsibility.

_____ **SELF-PAY (for non-covered products and services and for patients without insurance coverage):** Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

_____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

____ **NO SHOW(failure to present for your appointment): 24 hours-notice** is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours-notice** for a scheduled office procedure will incur a **$100** fee.

____ **SURGERY CANCELLATION:** Failure to provide **5 business-days** notice before surgery will incur a **$500** fee.

____ **BALANCES/COLLECTION FEES:** If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a **$10** re-billing fee may be added to each additional statement. Our patient portal offers the ability to view statements and submit payments conveniently and securely. Patients with balances more than 90 days overdue will be turned over to collections and a **$35** administrative fee will be applied.

____ **FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$25** charge for having the doctor complete these forms. Requested forms will be completed within 72 hours of diagnosis and care plan. There is a **$15** fee to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient Name (print):_____

Patient/Responsible Party Signature:_____

Date: _____/_____/_____