



**Insurance / Proof of Insurance.** We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we participate with, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage. Knowing your insurance benefits is your responsibility. All patients must provide their insurance card(s) and picture identification at the time of their visit.

**Co-payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Your appointment will be rescheduled if payment is not available at time of service. Returned checks are subject to a \$15.00 service fee. **A receipt will be provided for all payments at the check-out desk.**

**Referrals.** We are required to follow the guidelines of your managed care plan which mandates that when you visit a specialist such as ours, you MUST have a referral from your primary care physician prior to seeking specialty care. Therefore, you are responsible for verifying if you require a referral and that your referral is present at the time of your appointment. If you do not have a referral at the time of your appointment, your appointment will be rescheduled.

**Non-Covered Services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers.

**Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct insurance information or notify us of changes in insurance in a timely manner, you may be responsible for the balance of a claim.

**Claims submission.** The filing of insurance claims is a courtesy that we extend to our patients. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

**Prescription Refills/Renewals.** Please do not wait until your prescription runs out or has expired. Allow **24 hours notice** to review your refill or renewal request. Refill and/or renewal requests will only be processed **Monday through Friday** during normal business hours. Controlled drug substance (narcotic) prescriptions must be picked up in the office and may require you to schedule an appointment. Prescriptions will not be refilled after hours or on weekends.

**Patient Billing.** You will have up to 45 days after receiving your notice to pay your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company. After that time, your account will be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. We accept the following payment methods: cash, check, Visa, Mastercard, Discover. Returned checks are subject to a \$15.00 service fee. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

**Appointments.** We greatly appreciate you allowing us to provide you with the best care possible. Our office knows your time is important and we hope you understand the value of our time. We want to be able to provide every patient with all the attention they require. Therefore, if you are not on time for your appointment it may be necessary to reschedule for another day. Please provide us with 24 hour notice if you will not be able to maintain your appointment. If you miss 3 appointments in a row without appropriate notice, we may find it necessary to permanently dismiss you from our office as we cannot provide proper treatment to you when you regularly miss your scheduled appointments.

**Patient Conduct.** We have a **ZERO TOLERANCE** policy in our office for patient behavior that is deemed inappropriate. This may include, but not limited to, verbal and/or physical abuse, harassment or threats to any of our office staff as well as any damage to any of the physical property in our office including, but not limited to, furniture, fixtures/decorations, electronics and equipment. Such behavior will result in immediate and permanent dismissal from our office. Any such incident will be documented and if necessary, will be forwarded for legal intervention.

***Please note that refusal to accept and sign this office policy will prevent us from accepting you as a patient of Northeastern Foot & Ankle.***

**I have read and understand the above and agree to abide by its guidelines.** A copy will be provided to you upon request. Please let us know if you have any questions or concerns.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name