Ribeiro Foot & Ankle Center

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FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial polices as an essential element of your care and treatment.

I authorize payment of medical benefits to Dr. Carla Ribeiro-Bachtell for all services provided. As our patient, you are responsible for making sure that the bill is paid in full. All charges are your responsibility and not the insurance company's. We must emphasize, as your podiatric medical care provider, that our relationship is with you and not your insurance company. Your insurance is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. The filing of a medical insurance claim is an expensive process and a courtesy that we extend to you at no charge**. However, we do ask that you pay all co-pay, deductible and non-covered charges on the day of your service**. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. Self-pay patient are required to pay in full at the time of service unless prior arrangements have been made. If a service is not covered, applied to your deductible or part of your coinsurance, you will have (30) days to pay the balance in full. If you fail to pay in a timely manner, you understand that your account will be subject to collection proceedings. **All fees, including collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.**

If payment is not received in the (30) days required and additional statements must be sent to collect the balance**, a $10.00 re-billing fee** will be added to each statement until the balance is paid in full.

I understand that it is my responsibility to provide the office with my current insurance card at the time services are rendered to me. If I cannot provide my current insurance card, my appointment will be rescheduled or I will choose to pay for services out of my pocket.

I understand that if I provide incorrect or expired information, I will assume full financial responsibility for all charges incurred.

I understand that my account may be charged a **$30.00 cancellation** fee if I do not call to cancel my appointment at least (24) hours before my scheduled appointment time. There is a **$60.00 cancellation fee** for office procedures such as biopsies, nail procedures, wart removals, etc. This amount must be paid prior to any further visits with our office.

I understand that my account may be charged a **$150.00 cancellation fee** if I do not call to cancel my surgery at least (72) hours in advance before my scheduled surgery time. This amount must be paid prior to any future visits with our office.

For your convenience our office accepts all major credit cards, checks, and cash. You agree to be responsible for a **$25.00 service fee for all returned checks.**

The courts have established the x-rays are the property of the doctor who takes them as part of the patient's medical record. If you need to take your x-rays, copies of the films will have to be made after we receive a signed release from the patient**. There is $10.00 fee for this service.**

Medicare requires a minimum of 60 days between visits for at risk patients for routine foot and nail care. Please note that Medicare may not qualify for routine trimming of nails and/or calluses. Any charges outside of Medicare guidelines will be the responsibility of the patient.
By signing this document, I acknowledge that I have read it, understand and agree to the above stated terms and conditions.

Printed Name: _____

Signature: _____ Date_____