NORTH IDAHO
FOOT & ANKLE INSTITUTE

Financial Policy Addendum

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

Your insurance policy is a contract between you and your insurance company. We cannot assume that any specific charge will be covered. Your involvement in knowing what your plan covers is important and we encourage you to become familiar with your plan. This information is best obtained by contacting your insurance company and through your insurance booklet.

Co-payments, deductibles, and non-covered fees are the responsibility of the patient. They are due at the time of service.

Medicare: We are a participating Medicare provider. We will be collecting your 20% Medicare coinsurance and/or deductible (if applicable) at the time of your visit, **UNLESS** your secondary carrier is automatically "crossed-over" by Medicare. In that case, if your secondary carrier's reimbursement does not cover the co-insurance in full, you will be billed for the balance. Any amounts billed are due upon receipt.

Claim Submission: 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.

Self-Pay: Payment in full is due **at the time of service** if you do not have health insurance, unless other arrangements have been made in advance.

Cancellation Policy: If you are unable to keep your scheduled appointment, please call our office to reschedule or cancel at least 24 hours in advance. Patients who **NO SHOW** for an appointment or who do not cancel with proper notice may be assessed a **$35.00 NO SHOW** fee. This fee is not covered by any medical insurance.

High Deductible/Marketplace Plans: We are aware of the prevalence of high deductible plans available through the insurance marketplace. **You are responsible for all payments until your deductible has been met.** If you feel you will not reach your deductible for this year, and would like us to not bill your insurance, we offer a cash discount for payment in full on date of service. Further information can be provided upon request.

Please note, if you are currently receiving a **tax credit** and are not current with your insurance premiums, your insurance will not cover your visits. It is your responsibility to make sure your insurance is in effect.

Non-covered Services: Please be aware that not all services are covered by insurance. You are responsible for full payment of these services at the time of service.

Referrals and Authorizations (HMO, POS plans, etc.): If your insurance requires you to have a referral from your primary care physician, you will need to have that faxed to our office or brought with you to your appointment. If no referral is received by your appointment date, your insurance company will not cover your charges and **you will be responsible for payment.**

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Patient Billing: **All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE**. This arrangement is part of your contract with your insurance company. The insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier.

Collections Fee: If your account is delinquent, it will be forwarded to our collection agency. When your account is sent to a collections agency, a **40% fee** will be added. You bear complete financial responsibility for any fee(s) incurred.

For your convenience we accept cash, check, Visa, Mastercard, Discover, and payment plans through CareCredit. CareCredit works like a credit card, but is exclusive for healthcare services. They are able to offer up to 18 months of interest free financing (depending on the minimum amount applied.) They are our payment plan option. Additional plans through our office are generally not made and are only done so with proof of denial from Care Credit. An additional $25.00 will be added to your statement if the check is returned from your bank. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

Forms: There will be up to a **$20.00** charge for all forms that must be filled out by your physician. This will include **FMLA, disability, Aflac**, or any other type of form. Please allow **5 business days** to have forms completed.

_____I have read the above policy regarding my *financial responsibility* to **North Idaho Foot and Ankle Institute** for medical services provided. I agree to pay **North Idaho Foot and Ankle Institute** any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance and assign directly to **North Idaho foot and Ankle Institute** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____

Financially Responsible Party:

PRINT Name: _____Signature:_____

Relationship to Patient: _____Date:_____

Please fill out this section if you have a spouse, family member or friend you would like us to be able to talk to about any of your protected health information. **Without this we cannot disclose anything to anyone aside from your insurance company or other physicians on a referral basis**. I understand that I can cancel this release at any time by contacting the office and notifying them of any changes.

_____ _____ _____ _____

Person to be released to Relationship Person to be released to Relationship

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