

# FINANCIAL POLICY STATEMENT

## Arch Foot Care

Devang C. Patel, P.C.

Podiatrists-Medical and Surgical Foot Care Specialists

761 Main Avenue

Norwalk, CT 06851

You are responsible for knowing the benefits, limitations, deductibles, and/or restrictions that your policy may stipulate. We will facilitate the bill payment process to our best abilities. In order to avoid any misunderstandings, we ask that you confirm your benefits with your insurance carrier.

Please understand that the exact determination of benefits occurs at the time your insurance company processes and pays the claim. Every effort will be made to notify you should a difference occur between what was expected and what was actually paid. You should also receive notification directly from your insurance carrier concerning the benefits paid from your visit.

We must emphasize that our relationship is with you. I understand that my insurance policy is a contract between the carrier and myself, and that the doctor's office is not responsible for settling disputed claims. Our office will provide the necessary information regarding my treatment in order to facilitate payment of my claim. While filing of insurance claims is a service that we extend to our patients, it is your responsibility that the charges are paid in full.

**Any known out of pocket expenses including deductibles, co-pays, co-insurance, and/or non-covered services or supplies are due at the time of service.** Any amounts denied for any reason by your insurance carrier not known to us are due at the time of claim processing. Payment is expected at the time of treatment for all deductibles, co-pays, and co-insurance. I understand and agree that I am financially and legally responsible for full payment of my bill for services and that any failure of my insurance carrier to pay for all or any part of my bill does not constitute a reason for me not to pay.

Accounts that are unpaid are considered delinquent. These accounts will be referred to a collection agency and/or attorney for collection or small claims court. You, the patient are the responsible party and shall be responsible for all costs incurred for collections. These may include collection fees, attorney fees, and court costs.

I also understand and agree that the responsibility for obtaining referrals/authorizations for in network treatment is solely mine. I understand that I will be seen as an out-of-network patient if I do not obtain the appropriate referral for treatment. It will then be my responsibility for all unpaid benefits.

In addition, I have been advised that my failure and/or denial to provide accurate insurance information prior to, or upon my initial visit will mandate that this office will assign you as a self paying or uninsured cash patient. This classification will cause me to forfeit any in-network benefits that this office may accept as a participating provider. I will be reinstated as an insured patient once all documentation and referrals are provided.

I also understand that this office asks for a courteous 24 hours of notice for any change or cancellation of scheduled appointments. We understand that emergencies and other circumstances do occur.

I understand the financial policy and responsibility for my account.

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Patient/Responsible Party's Signature

Rev. 03.01.06

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Date