

# Policies and Procedures for Treasure Valley Podiatry/Podiatry Center of Idaho

Thank you for choosing us as your healthcare provider. We are committed to quality and caring treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our policies and procedures. Please read the information carefully. We do require you to read and sign all forms given prior to seeing the doctor.

*Payment in full is due at the time of each and every service. We accept cash, personal checks, Visa, MasterCard and Discover only. All co-pays, deductibles and co-insurance must be paid in full at the time of service. We do in some instances offer an extended payment plan. The payment plan must be set up before the patient can see the doctor.*

## **Insurance:**

If we are not contracting with your insurance plan we may accept assignment of benefits after your first visit. However, we do require (regardless if we are contracted with your insurance plan or not) that all patients pay their co-pay, deductible (if not satisfied) or co-insurance at each visit. The balance on your account is your responsibility regardless if your insurance plan pays your claim(s) or not. We will not and can not bill your insurance plan or Medicare unless you have supplied us with the copy of your current insurance plan and/or Medicare card and the complete policyholder information given on your registration form. Your insurance plan is a contract between you and your insurance only. We are not a party to that contract. We may bill your insurance plan(s) as a courtesy to you only.

If your insurance plan has not paid your claim(s) within 60 days and we have made a good faith attempt to send your claim to them, the claim balance will be transferred to your responsibility. It is then your responsibility to get your insurance plan to pay the claim(s). Please be aware that many podiatry services may not be covered, are deemed as not a medical necessity or require pre-authorization from your insurance plan or Medicare. We will do our best to inform you if we believe any services may fall under these restrictions. It is ultimately your responsibility to know your benefits and to pre-authorize any services with your insurance plan or Medicare that may need so. There may be a fee charged if your insurance plan requires pre-authorization from the physician or physicians office. This fee is not reimbursable by your insurance plan or Medicare and must be paid in advance prior to pre-authorization.

## **Usual and Customary Fees:**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. If we are not under contract with your insurance plan to accept their usual and customary fees you are ultimately responsible for the difference in the fees.

## **Payment:**

All patients are responsible for full payment at the time of service unless arrangements are made with the provider as stated in the paragraphs above prior to seeing the doctor.

## **Missed Appointments:**

At least 24 hours advanced notice is required for an appointment cancellation. Our policy is to charge for missed appointments at the rate of our normal office visit. Please help us, and the rest of our patients, by keeping scheduled appointments.

Thank you for your understanding of our policies and procedures. These policies and procedures are subject to change and you will be notified of such changes prior to seeing the doctor. Please let us know if you have any questions or concerns.

I have read and completed all forms to the best of my knowledge. I understand and agree to comply with all policies and procedures as stated in these forms. I will notify you of any changes to the information on my patient information sheet as they occur.

X \_\_\_\_\_

Signature of patient or parent/guardian if minor

\_\_\_\_\_ Date

Mark One:

I would like a copy of this form for my records

Save a tree. I do not need a copy of this form.

