

VINCENT C. MARINO, DPM, INC.
430 Davis Ct.
San Francisco, CA 94111
(415) 984-2700

FINANCIAL POLICY

Dear Patient:

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our office to provide your foot and ankle care. We appreciate your trust and look forward to keeping your feet and ankles healthy and happy.

As part of our service, we try to contain the ever rising cost of health care. In an effort to do this, we have implemented this *Financial Policy* which we ask you to read and sign. You may receive a copy of this policy for your records if you so desire. The original will be maintained in your patient chart.

INSURANCE BENEFITS AND COVERAGE

As a courtesy to you, our staff will attempt to contact your insurance company to verify your coverage benefits regarding podiatric medical care. We will make every effort to advise you if certain treatments are not covered by your plan. In doing this, we must rely on the information provided to us by your insurance company representatives. We do document the person we speak to and the date of the call. However, we can not be responsible if we are given false information by your company although this is very rare. Verification of coverage and eligibility IS NOT a guarantee that payment will be made by your insurance company. That is determined by your insurance company at the time the claim is submitted and reviewed. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you ever have any questions regarding your coverage, we will be happy to assist you in obtaining the answers. Ultimately, YOU are responsible for all costs incurred during treatment with the exception of PPO, HMO, or Preferred Provider adjustments and write-offs. These adjustments and write-offs are determined by the contracts the doctors have with your insurance company.

COPAYMENTS AND DEDUCTIBLES

Although we do accept assignment of insurance benefits as determined by our PPO, HMO, and Preferred Provider contracts with the various insurance companies and medical groups, we do require payment of any copayments, patient portion amounts, and any unpaid yearly deductible to be made at the time of service.

FEES

The filling out of forms for disability benefits shall be performed by the doctor upon your request. However, with the exception of the California State Disability form, we must impose a TEN dollar (\$10.00) fee for the completion of each form. This fee must be received at the time of the request or presentation of the form to be completed.

UNINSURED PATIENTS.

FULL payment is due at the time of service. We accept cash, checks, VISA, and MASTERCARD (no American Express please).

NONCOVERED BENEFITS

We realize unforeseen circumstances may arise or that some insurance companies, especially HMO's, may not cover some medically necessary services (e.g. Orthotics). In these instances, a payment plan MAY be available. These will be evaluated on a case by case basis. While we try to accommodate all our patients, we do maintain strict guidelines regarding payment plans. Failure to adhere to the payment schedule will result in a revocation of the payment plan agreement.

PRESCRIPTIVE FUNCTIONAL ORTHOTICS

If your podiatric medical condition warrants the fabrication of prescriptive functional orthoses, payment for them may be made in part by your insurance company. However, we do require a deposit from you consisting of \$200.00 **AT THE TIME OF CASTING if we are not able to verify coverage for this service.** Additionally, the payment for orthotics is **NOT** subject to PPO or HMO fee reductions. We will bill your insurance company for these devices but ultimately you are responsible for their cost of \$450.00. If your insurance company pays a part of the cost, then you will be held responsible for payment of the difference until \$450.00 has been received. Please be advised this amount of \$450.00 is our discounted cash price. We will be billing your insurance company for our usual and customary fee which is higher than our discounted cash fee. However, you will only be responsible for payment up to the \$450.00 fee level.

BALANCES AND STATEMENTS

You will receive a statement at the end of each month. If any payment is due, the statement will have a "**Pay This Amount**" section on it. This payment is due by the fifteenth of the month. If this payment has not been received by the next billing cycle, a "Rebilling" fee of \$15.00 (Fifteen) will be added to your balance. This will be repeated each month. Additionally, interest will begin to accrue at the rate of 1.5% per month compounded monthly if payment has not been received. If you have difficulty making a payment, you **MUST** contact us **PRIOR** to the due date to avoid these fees.

In order to refrain from raising our fees, we must control our costs and maintain efficiency in the business aspect of the practice. We are dedicated to providing you and your family with the best possible foot and ankle care available. We will also attempt to accommodate you whenever possible. If you have any questions regarding this ***Financial Policy*** or any other matter, please contact a member of the staff who will be happy to discuss them with you. Thank you for your understanding. We look forward to serving all your foot and ankle needs.

I, _____, have read this ***Financial Policy***,
(Print Name)
understand it, and agree to its terms.

X _____ Date _____
(Signature of patient or responsible party)