

# BATAVIA FOOT CARE CENTER

3922 WEST MAIN STREET ROAD  
BATAVIA, NY 14020

## OFFICE FINANCIAL POLICY

This financial policy has been established to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying for their medical care.

- **INSURANCE:** WE MUST OBTAIN A COPY OF YOUR INSURANCE CARD TO PROVIDE PROOF OF INSURANCE. WE WILL BILL YOUR INSURANCE, BUT IF PAYMENT IS DENIED, YOU, THE PATIENT, WILL BE RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED BY THE PARTICIPATING DOCTORS AT BATAVIA FOOT CARE CENTER. **KNOWING YOUR INSURANCE IS YOUR RESPONSIBILITY. THIS ARRANGEMENT IS PART OF YOUR CONTRACT WITH YOUR INSURANCE COMPANY. PLEASE CONTACT YOUR INSURANCE COMPANY WITH ANY QUESTIONS YOU MAY HAVE REGARDING YOUR COVERAGE.**
  - **CO-PAYS:** I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY MY CO-PAY ON THE DAY SERVICE IS RENDERED. IF CO-PAYMENTS CANNOT BE MADE AT THE TIME OF YOUR VISIT, A \$15.00 SURCHARGE WILL BE ADDED TO YOUR ACCOUNT.
  - **DEDUCTIBLE OR COINSURANCE:** PRIOR TO YOUR SCHEDULED APPOINTMENT AT BFCC, OUR DEDICATED STAFF WILL CHECK YOUR INSURANCE ELIGIBILITY AND CALCULATE ANY DEDUCTIBLE OR COINSURANCE YOU MAY BE RESPONSIBLE FOR PER YOUR INSURANCE CONTRACT. THIS CALCULATED ESTIMATION WILL BE COLLECTED ON THE DATE OF YOUR APPOINTMENT. ANY BALANCE WILL BE BILLED TO YOU AND ANY OVERPAYMENT WILL BE CREDITED TO YOUR ACCOUNT.
- **PAYMENT:** WE ACCEPT VISA, MASTERCARD, DISCOVER, CASH & CHECKS.
- **REFUNDS:** BFCC WILL ISSUE PATIENT REFUNDS BY CHECK WITHIN 30 DAYS OF A COMPLETED INVESTIGATION OF ALL POTENTIAL OVERPAYMENT, AS LONG AS ALL OUTSTANDING BALANCES HAVE BEEN RESOLVED ON YOUR ACCOUNT & NO FURTHER APPOINTMENTS ARE SCHEDULED.
- **APPOINTMENTS:** IF ANY APPOINTMENT IS BROKEN OR CANCELLED WITHOUT GIVING 24 HOUR NOTICE OR NOT SHOWING UP FOR YOUR APPOINTMENT, A CHARGE OF \$50.00 WILL BE APPLIED TO YOUR ACCOUNT & PAYABLE PRIOR TO YOUR NEXT APPOINTMENT. EXCESSIVE ABUSE OF SCHEDULED APPOINTMENTS MAY RESULT IN DISCHARGE FROM THE PRACTICE AND/OR REFERRED TO COLLECTIONS.
- **MEDICAID:** IF YOU HAVE MEDICAID AS A SECONDARY INSURANCE TO ANY OTHER INSURANCE, PLEASE BE ADVISED THAT IF YOUR MEDICAID COVERAGE IS NOT ACTIVE ON YOUR DAY OF SERVICE, YOU WILL BE RESPONSIBLE FOR YOUR COPAY AND ANY BALANCE AFTER YOUR PRIMARY INSURANCE. **I UNDERSTAND AND AGREE TO THIS TERM: PLEASE INITIAL: \_\_\_\_\_**
- **ASSIGNMENT OF BENEFITS:** I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PARTICIPATING DOCTORS AT BATAVIA FOOT CARE CENTER FOR SERVICES RENDERED TO ME.
- **NON-PAYMENT / COLLECTION:** ANY BALANCE TO AN ACCOUNT IS DUE WITHIN 30 DAYS OF RECEIPT OF BILL. IF THE ACCOUNT BALANCE GOES UNPAID, A REBILLING CHARGE OF \$10.00 PER MONTH WILL BE APPLIED TO YOUR ACCOUNT. IT IS UNDERSTOOD AND AGREED THAT IN THE EVENT ANY OUTSTANDING BALANCE HAS TO BE REFERRED TO A COLLECTION AGENT OR ATTORNEY FOR RECOVERY, YOU AGREE TO REIMBURSE US ANY FEES OF ANY COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF UP TO 50% OF THE DEBT, AND ALL COSTS, AND EXPENSES, INCLUDING REASONABLE ATTORNEYS' FEES, WE INCUR IN SUCH COLLECTION EFFORTS.
- **NON-COVERED SERVICES:** PLEASE BE AWARE THAT SOME & PERHAPS ALL OF THE SERVICES YOU RECEIVE MAY BE NON-COVERED OR NOT CONSIDERED REASONABLE OR NECESSARY BY MEDICARE OR OTHER INSURANCES. YOU MUST PAY FOR THESE SERVICES IN FULL AT THE TIME OF THE VISIT.
- **SELF PAY:** PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE DELIVERED.
- **MEDICAL RECORDS:** THE COST FOR COPIED MEDICAL RECORDS & COMPLETION OF DISABILITY FORMS WILL BE CHARGED TO THE PATIENT AND COLLECTED PRIOR TO COMPLETING THE REQUEST. THE FEES FOR THESE SERVICES ARE REGULATED BY HIPAA & NEW YORK STATE HEALTH DEPARTMENT.
- **RETURNED CHECKS:** RETURNED CHECKS ARE SUBJECT TO A \$30.00 SERVICE CHARGE. IN THE EVENT OF A RETURNED CHECK YOUR PRIVILEGE TO PAY BY CHECK ON FUTURE VISITS WILL BE TERMINATED. YOU WILL BE SUBSEQUENTLY EXPECTED TO PAY WITH CASH OR CREDIT CARD.

**PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ AND FULLY UNDERSTAND THIS POLICY.**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE PRINT

SIGNATURE: **XX** \_\_\_\_\_

SIGNATURE

RELATIONSHIP IF LEGAL GUARDIAN

REVISED: 1/2018