Northeast Foot Care, PLLC
Dr. David Lambarski, DPM, FACFAS

Office Policies

As a courtesy to you, we bill your primary insurance carrier directly, and await their portion of payment due on your physicians services account. You will be responsible for paying any portion of the bill that the insurance company states is your responsibility. We accept cash, credit cards, and checks.

CO-PAYMENTS

- As Northeast Foot Care, PLLC is both a participating provider for select insurance companies and a fee-for-service office, your co-payment and deductible are due in full on each date of service.
- **If your co-payment is not paid at the time of service, you will be charged a $20.00 service charge.**
- Your insurance company may require co-payments for office visits AND other services including x-rays, etc.

BILLING/PAYMENT INFORMATION

- **In the event your insurance carrier denies payment for physician services rendered, for any reason, you are responsible for your account in full.**
- Your insurance company may pay a benefit base on "usual and customary" charges as determined by their reviewers. You may still have a balance for which you are responsible, in addition to your co-payment, for such services.
- **If your account/patient due balance becomes 90 days delinquent, your account will be charged 20% APR until balance is paid in full.**
- **Only PAYMENT PLANS signed and approved by Dr. Lambarski are considered valid.**

REFERRALS/INSURANCE INFORMATION

If your insurance company requires a referral and one is not provided to you, you may be asked to reschedule your appointment or be asked to sign a waiver of liability form if insurance requires one then you may be responsible for paying that visit in full if insurance denies. If your insurance company requires referrals, forms or special signatures, it is your responsibility to obtain or provide them.

The above insurance coverage information does not guarantee payment in any way. We do not accept responsibility for any incorrect information given to us by your insurance company. Please be aware that your insurance company may send letter and/or checks for physician services to you, throughout your care. You are responsible for forwarding these items to us, if required to maintain payment and/or care of your account.

Routine Release of Information and Assignment of Benefits

- Unless otherwise specified, I authorize Northeast Foot Care, PLLC to release any records, reports, radiographs, and any other information requested by an insurance company, hospital, medical provider, health center, physician, and/or any of my family members.
- I authorize the payment of benefits to supplier for physician services rendered.
- I have been told that I will ultimately be responsible for any part of my physician services bill not covered by my insurance carriers.
- I understand that this information will be shared only with authorized persons and will be considered strictly confidential.
- I have read, understand, and agree to abide by all of the above guidelines and information.

Patient/Guarantor Signature:______________________________ Date:______________________________

revised 03.28.2012