FINANCIAL POLICY

Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please discuss them with our billing specialists.

Regarding insurance: Our office participates with Medicare, Medicaid and many commercial insurance companies. Should your insurance coverage be with one or more of these companies, we will bill your insurance company in accordance with the guidelines of our provider contact. **Co-payments, co-insurance, deductibles, non-covered services, and medical supplies are the responsibility of the patient or legal guardian and payment is required at the time of services for these.** Workers' compensation and/or accident claims must be verified with your employer or the Third-Party insurance provider such as Workman's compensation insurance provider or Auto insurance company before your date of service. ***It is your responsibility to confirm with your insurance company to ensure that our facilities and physicians are in network with your insurance policy. It is also your responsibility to confirm what your policy benefits are for services provided.*** It is your responsibility to pay for any charges you incur that your insurance does not cover. Being seen by one of the providers in our office does not assume or confirm insurance benefits for services rendered. While we do the best we can to assist you in confirming that you are in-network with our clinic and to understand your policy, **it is ultimately your responsibility to understand your policy as that is a contract between you and your insurer.** ***You are responsible for all charges not covered by insurance, based on your contract with your insurer.*** If we are not in the network and you would still like to be seen at one of our facilities, you will be considered self-pay. We will submit to your insurance only upon your request to see if you have out of network coverage, however, you must pay for the services up front. You will be credited back for any portion of your services that your insurance does cover.

Co-Pays: All co-payments are due at the time of service without exception. If you do not have your co-payment or deductible payment, you will be asked to reschedule your appointment for a later date.

Financial Responsibility – Deductible & Co-Insurance Payment Policy for commercial insurance carriers (Medicare with supplement and/or Medicaid is excluded)

- New patients who have not met their annual deductible are required to pay **$150** (or what remains if less than $150 remains) towards the deductible at the time of evaluation service ***in addition to their contracted co-pay obligation. ****
- Existing patients who have not met their annual deductible will be required to pay $75 towards the deductible at the time of evaluation service ***in addition to their contracted co-pay obligation. ****
- In Clinic Procedure Deductible Payment – If your treatment requires a procedure and the annual deductible has not been met you will be asked to pay ***50% of the procedure cost*** up to the amount of your remaining deductible on the day of the procedure. *
- Outpatient Procedure Deductible Payment – If you have not met your deductible *3 weeks prior* to your scheduled surgery you will be ***required to pay up to 50% (or the remaining deductible, whichever is less) of the anticipated charges*** from the surgeons at Foot & Ankle Center of Iowa. **The payment will be due no later than 10 days prior to your surgery date.** (This does not include any facility or anesthesia charges).*
- Outpatient Procedure Co-Insurance Payment – If you have a co-insurance responsibility this will be determined after your deductible payment is determined. The deductible payment will be considered when determining your estimated co-insurance responsibility. **The co-insurance payment, in addition to your deductible payment, will be due no later than 10 days prior to your surgery date.** (This does not include any facility or anesthesia charges). *
- There is a separate deposit for surgical scheduling in order to hold your surgical spot. (See surgery scheduling deposit form.)

*We must use the information that is available to us at the time of service or required payment time in the case of outpatient procedures, when determining your remaining deductible. We realize that payments may have been made that insurance has not processed yet, however, it is our policy to use the information that is available from your insurer at that time. If there is a credit to your account after your insurance has been processed (it typically takes 30-90 days for this), then the amount of overpayment will be refunded to you within 30 days of final adjudication (processing) by your insurance.

Uninsured patients: If you are uninsured, our billing office will attempt to provide a free estimate of expected charges based on the anticipated services. We require all uninsured patients to provide a $300 deposit prior to receiving services. This can be paid in cash, debit card or credit card. Final charges will be determined by your provider at the completion of your visit. If the charges are less than the deposit, you will receive an immediate refund. If the charges exceed $300, payment is required at that time.

Referral Needed: You are responsible for obtaining any necessary referral if required by your insurance company. If a referral is not obtained and is necessary, you are responsible for full payment.

Fee Schedule:

- Returned check fee is $40.00
- Paperwork fee/Chart request is: First copy is free to the patient if picked up; mailing fees apply. Subsequent copies at $7 per visit if 1-2 visits; $20 flat fee for more than 2 visits. $50.00 per chart for third-party requests.
- No show fee is $40. This will be billed to the card on file if no call is received to cancel or reschedule your appointment by the time of your visit.
- X-Ray Copy Fee $10
- If mailing of documents or x-rays is requested then the patient is responsible for the mailing fee as well as the processing fee.
- FMLA/Short Term Disability Administration fee is $40. We have up to 7 business days to complete this paperwork.

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Patient or Guardian Signature Printed Patient Name Date

CREDIT CARD ON FILE AGREEMENT

Foot and Ankle Center of Iowa requires a credit card to be kept on file. Once insurance processes, if a payment is due then you will be sent a statement via email and/or the portal notifying you of the charge to process. If you elect to pay in a manner different from your card on file, please notify us immediately upon receipt. If we are not contacted within 4 days of receipt of the notification to use a different form of payment the credit card on file will be charged with the outstanding balance. If the card does not process and the payment is not made, then finance charges will accrue on the outstanding balance per our interest policy. Finance charges will accrue at a rate of 1.25% per month. It is your responsibility to notify us of any email and mailing address changes in a timely manner to prevent delay of invoice delivery.

By electing to been seen by one of the providers at Foot and Ankle Center of Iowa, I agree to allow Foot and Ankle Center of Iowa to charge my credit card on file for any amount not covered by insurance (up to the maximum charge amount), for all services provided by Foot and Ankle Center of Iowa to the patient(s) on or after the effective date and before the expiration dated. I acknowledge that:

- My card will be charged upon review of the final explanation of benefits (EOB) from each applicable insurance company for services provided while this agreement is in effect. My card will be charged 5 days after I receive an email notification.

- Once a total of $5,000.00 has been charged to my credit card under this agreement, Foot and Ankle Center of Iowa will bill me directly for any amounts not covered by insurance.
- My card will be stored by Elavon, Inc., a secure credit card processor affiliated with U.S. Bank that partners with Foot and Ankle Center of Iowa to collect payments.
- I will receive receipts detailing the amount charged via email. If my email changes it is my responsibility to make Foot and Ankle Center of Iowa aware of this change.
- I may cancel this agreement at any time by contacting Foot and Ankle Center of Iowa; any unpaid amounts relating to services provided while this agreement is in effect will need to be paid at that time.
- I understand that if I elect to not have a card on file then I will not be able to receive services at Foot and Ankle Center of Iowa.

COLLECTION AUTHORIZATION

If your account balance is not paid in a timely fashion, your account will be suspended and sent to a Third-Party Collection Agency. Patients will need be able to schedule an appointment if their account is in collections.

By signing below, I will be responsible for paying all Collection Agency Fees assessed by the Third-Party Collection Agency. I agree, in order for the Foot and Ankle Center of Iowa to service my account or collect any amount that I may owe, unless otherwise prohibited by applicable law, the Foot and Ankle Center of Iowa or a designated Third Party Collection Agency are authorized to (i) contact me by telephone at the telephone number(s) in the patron contact account information I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide any/or (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

By signing below, I acknowledge that I have read this disclosure, had the opportunity to ask questions on the policy and agree that the Foot and Ankle Center of Iowa or Third-Party Collection Agency may collect payment ad may contact me as described above.

AUTHORIZATION TO TREAT

By signing below, I authorize treatment by any one of the providers of the Foot and Ankle Center of Iowa. I authorize the release of any information requested by insurance companies or liable third parties and assign any insurance benefits to the Foot and Ankle Center of Iowa. If the correct insurance information is not given and/or proper referral is not obtained, I understand that I will be responsible for all charges.

NONDISCRIMINATION STATEMENT

The Foot and Ankle Center of Iowa and its subsidiaries comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Foot and Ankle Center of Iowa does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. By signing below, I acknowledge that I have been offered and/or declined a copy of the “Notice informing individuals about nondiscrimination and accessibility requirements and nondiscrimination statement.”

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Patient or Guardian Signature Printed Patient Name Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- I need to sign this form even if I don't name anyone to disclose my information to.

May we phone, email, or send a text to you to confirm appointments and remind you of payments due? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with anyone besides you? YES NO

If YES, please name those we are allowed to speak to: (If you know a date of birth or phone number please add.)

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Patient Printed Name: _____

Patient Signature: _____

Minor:

Parent/Guardian Signature:_____

Relationship to Patient:_____