Patient Financial Policy

Foot and Ankle Center of Durham, A Division of InStride Foot and Ankle Specialists, PLLC

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check. Copay, co-insurance, or deductible will be due at the time services are rendered. You may receive a bill for any fees deemed as a patient responsibility after the claim has been settled with your insurance provider.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We made prior arrangements with certain insurers and health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the copay/coinsurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you are responsible for charges for service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any denied charges.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- **Self pay patient**s will be asked to pay a deposit before services are rendered. A final patient responsibility will be collected after treatment is completed.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- I agree to pick-up and pay for any custom orthotics or braces for which I am casted or 3D scanned.
- **MEDICAID** patients: We do not accept Medicaid for adults (anyone over the age of 18). This form acknowledges that you have been made aware. You agree to pay any fee or cost deemed as a patient responsibility.
- There is a **$25.00 "NO SHOW"** fee for failure to reschedule or cancel your appointment at least 24 hours in advance of your scheduled appointment.
- I understand **NAIL AND CALLUS TRIMMING** are not automatically covered by my insurance. They are not automatically covered even if I pay a Copay, Co-insurance, or Deductible that is applied towards my office visit. I understand that nail and callus trimming are two different services and are billed separately.

Signature of Patient/Responsible Party X____

Printed Name of Patient/Responsible Party______________________**Date:**___/___/___