Central Virginia Foot and Ankle

MICHAEL A. GOLDMAN, D.P.M.
Diplomate, American Board of Podiatric Surgery

Patient: _____ Date: _____

MEDICAL RELEASE AUTHORIZATION

"I request that payment of authorized Medicare/Medicaid/other private insurance benefits be made on my behalf to Michael A. Goldman, D.P.M. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me be released to Michael A. Goldman, D.P.M. or other applicable insurance carriers and its agents of any information needed to determine these benefits payable for related services."

Patient Signature: _____ Witness: _____

BILLING POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our billing staff.

MEDICARE. We are participating providers under Medicare and will file all Medicare claims and accept the fees set by the Medicare program for covered medical services, including surgery. Medicare patients will be responsible for copayments, annual deductibles and all non-covered services. **Routine foot exams are not covered by Medicare and payment is expected at the time of service.**

ROUTINE FOOT EXAMS. Exams are considered "**routine**" when there is not an established medical diagnosis or presenting symptom(s) to warrant the evaluation. Medicare and most other private insurance carriers do not recognize screening examinations and routine foot care as covered services. Therefore, payment will be expected at the time of service.

PRIVATE INSURANCE CARRIERS. We participate in a variety of other private insurance plans and will directly bill your insurance under these plans. In this circumstance, **you are responsible for applicable co-payments at the time of service.** If you have not met your deductible, you may pay at the time of your visit or we will bill you after receiving a response from your insurance company. **Services not covered by your insurance company are your responsibility.** We cannot accept responsibility for negotiating claims with individual insurance companies, and you are responsible for payment of your medical care within a reasonable time, regardless of the status of the claim. If *we do not* participate with your insurance company, we may bill your insurance as a courtesy, but full payment for services may be due at the time of service depending on your policy or plan coverage.

ACQUIRING REFERRAL AUTHORIZATION. Some private insurance carriers require that you obtain authorization for services from your primary care provider **before** your examination. It is your responsibility to understand the conditions of your individual coverage and obtain the appropriate authorization as needed. Contact your insurer directly if you have any questions concerning these policies.

INSURANCE COUNSELING. Before any surgical procedure which may entail greater expense, our office will provide insurance coverage information and estimate what, if any, balance may remain once insurance has paid. If special financial circumstances warrant an extended payment plan, our staff will be happy to discuss the arrangements with you as requested.

COLLECTION PROCEDURES. **Our office *accepts cash and checks only*.** Payment is expected in full for all non-insured patients or for those patients unable or unwilling to provide copies of their current insurance cards. Outstanding balances not collected at the time of service are due within 30 days of receipt of the first billing to avoid further collection action. Payment in full of any past due balance is expected prior to being seen in our office in the future, and payment in full will be expected at the time of service for any future services.

I have read and fully understand the billing policies set forth by Michael A. Goldman, D.P.M. I agree to the terms of these policies and understand that the terms may be amended by the practice at any time without prior notification to the patient.

Patient Signature: _____ Date: _____