Patient Name _____ Date of Birth _____

SIGNATURE
MEDICAL GROUP OF KC, P.A.

Associated Podiatrists
Financial Policy

YOUR BILL IS YOUR RESPONSIBILITY. Our pledge to you is to provide the highest quality podiatry care to you at the lowest possible cost.

We accept cash, check, Visa, MasterCard, Discover, American Express, and most insurance programs.

If you do not have insurance, review SMG-KC's Uninsured Patient Discount Policy.

If you have insurance, the following apply:

1. It is **YOUR** responsibility to give us the valid information about your insurance company, and to follow your insurance policies. We will assist you, but if claims are denied because of your failure to comply with your insurance policies, you will be responsible for paying the denied services.

2. You are responsible for paying any deductibles, co-payments, co-insurance, or non-covered services, per your insurance policy. You will present your insurance card(s) at every date of service.

3. Work Related Injuries:
   a. If your employer has approved treatment, you will not be charged or billed.
   b. If your employer does not approve treatment and you select us for your treatment, you will be billed and charged for services.

4. If you are involved in a lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.

5. We file group insurance claims and, by law, must file Medicare claims.

If you have a balance on your account, it will be collected in addition to your specialty co-pay, if applicable. In order to remain compliant with our insurance contracts, specialty co-payments are due upon check-in. Prior to scheduling procedures, a deposit may be required from you to cover any remaining deductible and/or co-insurance, as determined by your insurance policy. Payment for balances are due within 30 days of date of statement.

Accounts may be reviewed for outside collection activity if there is a remaining balance 90 days after the date of service. In this event, you may be responsible for any legal and/or collections fees. The collection fee is based on the statutes of the State of Kansas and the total balance turned over to the outside collection agency.

I have read and agree to comply with all of the above terms.

Signed _____ Date _____
Patient/Responsible Party