Alexandria Family Podiatry
2843 Duke Street, Alexandria, VA 22314
Phone: (703) 823-2357 Fax: (703) 823-1572

Dr. Richard G. Lee
Dr. Steven H. Lin
Dr. Neda Arjomandi

Insurance and Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility. For your convenience, we accept cash, check, and/or visa, MasterCard, Discover. If you have health insurance, you will need to pay your portion (co-pay and/or deductible) at time of service. It is your responsibility to know what is required.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will assist you as much as possible in obtaining prior authorization, referrals or answers to your questions, but it is ultimately your responsibility to check with your insurance company to determine eligibility, co-payment amounts, deductibles, covered services, referrals, etc. Disagreements and misunderstanding with your insurance carriers are not between this office and the insurance company, but rather between YOU and the insurance company. This can be avoided when you are personally involved. Your carrier is far more likely to respond to requests or complaints directly from you since you pay the premiums. Remember, you are responsible for the timely payment of your account.

Contract to Pay

Please read and sign below:

In consideration of professional services rendered to the above patient, I/we agree to pay co-pay and/or deductible at time of services. I understand that I am financially responsible for all charges whether they are eligible for payment by my insurance carrier or not. I/we authorize the doctor to receive assignment of insurance payments. If the customary charges are more than the benefits allowed under my insurance plan, I/we agree to pay the difference. Should my balance due be left unpaid after 90 days with no real attempt of payment made in a reasonable amount of time, my account will be referred to a collection agency. I agree to pay 33 1⁄3% of collection charges and 18% interest per annum on the unpaid balance. This includes, but is not limited to all court costs and reasonable attorney fees.

It is also understood and agreed that I/we cancel any appointment at least 24 hours in advance so that Alexandria Family Podiatry can accommodate another patient at that appointment time. If I/we fail to cancel within 24 hours, I/we may be charged a fee of $60.00. I understand that this charge is not reimbursable by my insurance company and is my sole responsibility.

I/we hereby authorize Alexandria Family Podiatry to administer such medications and immunizations and to perform such diagnostic/medical/surgical procedures as may be necessary for proper health care. I am aware that any major lab work may be sent to an outside lab, and I will receive an additional bill from that facility. I am aware that pathology may be sent to an outside pathologist for a second opinion.

My/our signature below signifies my/our understanding of the terms and conditions of Alexandria Family Podiatry's Insurance and Financial Policy, contract to pay for medical services, and the release of medical Information.

- **I/we acknowledge that a notice of privacy practices has been provided for my/our information and review. You may request a copy to review from Betty Glaze. (Check one)** ☐ **Yes** ☐ **No**

- **My pathology results may be given to someone other than myself. (Check one)** ☐ **Yes** ☐ **No**

PLEASE SIGN: X _____

Patient Signature **Date**