DR.TREPAL & JULES DPM

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

- As our patient, you are responsible for all 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 **cash or check.**
- 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 doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- 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 services or referrals; however you remain responsible for charges to any services 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 authorizations/referral requirements, in the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require pre-payment. 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 or at the time of your pre-op appointment.
- Patients who are 90 days past due on their balance will be sent to collections, unless a payment plan has been put into place.
- There is a service fee of **$25.00 for all return checks**. Your insurance company does not cover this fee.
- In fairness to all of our patients, we understand that emergencies occur, but **no shows or cancellations with less than 24 hours notice will result in a fee of $50.00.**

Signature of Patient / Responsible Party: _____ Date: _____

Printed Name of Patient/ Responsible Party: _____