Ambulatory Foot Center
Podiatric Medicine and Surgery
Adults and Children
Foot Specialists

1619 NW Hawthorne Ave. St 110
Grants Pass, OR 97526
(541) 471-7056 Fax (541) 474-3201

POLICY ON PATIENT ACCOUNTS

AMBULATORY FOOT CENTER provides quality care for what we believe to be fair and reasonable fees. Therefore, all accounts are administered under the following guidelines:

1. Any first-time patient at Ambulatory Foot Center is required to pay for his/her visit on the day of service, if the service is not covered by the health insurance. A financial payment plan may be set up ahead of time.

2. **Co-pays must always be paid on the day of the visit.**

3. It is the **PATIENT'S RESPONSIBILITY** to provide up to date and accurate insurance information to AFC. In the event your insurance company changes and we were not notified of the changes and/or it is necessary to re-bill your insurance company there will be a $5.00 charge per re-bill.

4. If you have a balance on your account, you will receive a monthly statement until the account is paid in full. After 60 days there will be a statement fee of $5.00 attached.

5. **PAYMENT OPTIONS:** Payment options include cash, check, Visa or MasterCard.

   MEDICARE PATIENTS: Ambulatory Foot Center, is a participating provider with Medicare, Medicare will pay 80% of the allowable fee, minus your annual deductible. If your deductible has not been met, you will be responsible for the full deductible and the 20%. This can be paid through supplement insurance or any of the listed (above) payment options.

6. **SECONDARY/SUPPLEMENT INSURANCE:** We bill the majority of secondary/supplemental insurance companies. If your insurance company sends the payment to you, it is your responsibility to send the payment to Ambulatory Foot Center.

7. **Patients are encouraged** to clear all accounts within 60 days or make payment arrangements. If no payments have been received 60 days after the first billing date, collection proceedings will begin and a $100.00 default fee will be charged.

8. **FORMS:** There is a $15.00 fee for any form that the physician is asked to complete. This is payable at the completion of the form. This fee cannot be billed to your insurance.

9. All bills are due and payable upon receipt of your monthly statement. If you have special financial needs, please feel free to discuss this with out office in order to establish an extension of credit terms.

10. **Cancellation Policy:** There will be a **$25.00 or $50.00** (30 minutes or longer) fee for appointments that are not kept or cancelled without 24 hour notification.

I have read the above policy statement; I agree to the conditions and upon request I will receive a copy.

Patient signature _____ Date _____