FINANCIAL POLICY FOR BLOOMFIELD FAMILY FOOT CARE

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. if you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for each service performed.

SECONDARY INSURACE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/ AUTHORIZATIONS: We are required to the follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of visit. If you do not have a referral from your primary care physician at the time of your visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if referral is presented to the office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claim and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your

responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account might be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made.

SUHA KASSAB D.P.M.
Medical & Surgical Foot and Ankle Specialist

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Dearborn, MI 48126
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I authorize use of this form on all my insurance submissions.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in place of the original.

I agree to pay all deductibles, co-payments, and non covered services at the time of service unless payment arrangements are made.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Financial Policy

Your insurance policy is a contract between you and your insurance company. We agree to submit, on your behalf, our billing statements to your insurance company. Some insurance companies do not fully cover podiatry benefits; in this event you may be responsible for some or all of our charges.

I have read and understand this financial policy and agree to its terms.

Print Name: ____

Signature: ____ Date: _____________________