

STILWELL FOOT & ANKLE

www.stilwellfeet.com

FINANCIAL POLICY

Thank you for choosing our office for your foot & ankle health care needs. We are committed to your *treatment* being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions in regards to our financial policy, please contact our office at 970.259.5303.

Charges for medical services are due and payable at the time services are rendered. Charges for medical care provided by this medical practice will be billed through our office and should not be confused with charges for medical care provided by the hospital. We accept Visa, MasterCard, Discover, American Express, and Care Credit as well as personal checks, money orders and cash.

Contracted Insurance: We directly contract, through physician organizations or independently, to provide service for some insurance companies; contact our office if you have questions in regards to our office being contracted with your insurance company. If we are contracted with your insurance company you will be responsible for your co-pay, co-insurance, deductible and any non-covered items/supplies *due at the time of service*. Any balance remaining after the insurance payment is made is due to our office within 30 days.

Non-contracted Insurance: Patients who have policies with non-contracted insurance companies will be responsible for payment in full for all office visits/procedures at the time service is rendered. We will bill your insurance company and you should be reimbursed directly. **We do not participate TRI/CARE Insurance WPS TRI West, however we bill using the Government Fee Schedule.**

Medicare: We are not contracted with Medicare. Patients who have Medicare will be responsible for payment at the time of service. We will only charge the Medicare allowed fees and submit your claim to Medicare, you should be reimbursed directly from Medicare.

We do not bill secondary insurances.

Self Pay/No-Insurance Patients: We will offer a 30% discount off of services rendered with the exception of supplies to all cash paying patients. We make no arrangements for long-term payments on patient balances.

I understand that if, 45 days after billing, my insurance has not paid, my account will be due and payable by me. In the event my account becomes past due, my balance will accrue interest at the rate of 18% per month. In addition, I will be responsible for collections costs, attorney fees, court costs and any other miscellaneous fees. I consent to have the collection agency obtain my credit report for the purposes of collection on my account.

In accordance with guidelines set forth by Colorado State Board of Medical Examiners, if further action must be taken on my account, I may be discharged from this practice and be required to seek further care elsewhere.

Returned Check Fee: We will assess a \$20.00 fee plus any additional charges allowed by CRS 13-1-109 for any returned check. All payments thereafter must be made with cash or credit cards.

I understand that certain services may be sent to an outside source such as lab, pathology and diagnostic services and thus will be billed separately for those services.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at \$72.00.

We will work with patients in any way we can to ensure that their medical care is the finest available and that this care does not become a financial burden. Please sign and date this form, acknowledging that you have read and understood our financial policy. Thank you.

I have read the financial policy above and understand and agree to these arrangements.

Print Patient Name

Signature of responsible party

Date