FINANCIAL POLICIES OF BEST FOOT FORWARD SURGICAL PODIATRY

-BFF participates in many insurance plans. Some plans have stipulations that prevent participation. Dr. Baker makes every effort to participate in your insurance plan. It is important that when you schedule your appointment or present to the office, you have the correct insurance documentation and identification so that coverage information can be obtained. Your social security number is necessary to file your insurance correctly. If you refuse to provide it and we cannot determine the correct benefits, you will be billed and you are responsible to file them to your insurance correctly. -It is the patient's responsibility to know or inquire about his/her insurance plan's deductible, co-pays, referral policy, etc. Such fees are expected to be paid at the time service is provided.

-Dr. Baker is a participating provider in Medicare. All Medicare patients have an annual deductible that must be met before coverage ensues. Typically, 20% of the service or procedure is due. Secondary insurance, when applicable will be billed for you, after an EOB from your primary insurance is received.
-If your insurance does not cover a procedure or service, regardless of any insurance policy, by signing below you agree that you received services or procedures and care by Dr. Baker that which assumed an appropriate charge. Your insurance benefits are a contractual between you and the insurance company. Should they not pay a claim you will be responsible for payment. In all cases, BFF will work with you and your insurance to obtain payment acceptable to all.
-Self-pay patients and patients paying on non-covered services, will be charged a flat rate of 50% of the cost per service or procedure of the Medicare allowable. Again, BFF podiatry wants to help you so please ask for any explanation of any of these policies. If you get a statement that you do not agree with or believe is in error, please call the billing company listed on your statement. Dr. Baker will coordinate with you and the billing company for a solution.
-Dr. Baker is a specialist. If your managed care plan mandates that a referral from your primary doctor is required to see a specialist, you must present the referral at the time of your appointment. If you do not have the referral in writing, you will be rescheduled or may pay as self-pay. Fees are due that day. No attempt will be made to call the physician for an immediate referral.
-Up to 3 statements are sent to you after all correspondence with insurances has been made on your behalf for payment. You are responsible for any payments after Explanations Of Benefits have been obtained. If you are unable to pay, please call the billing company. Payment arrangements are determined on an individual basis. Returned checks are assessed a fine of $35. Bad debt accrued must be paid prior to rescheduling. There is a $35.00 no-show fee assessed after the second no-show. That must be paid prior to re-scheduling.
-Dr. Baker contracts with a billing service. As affiliates of this office, said affiliates will abide by all HIPAA, confidentiality and equality regulations. By signing below, you understand and agree to exchange of all necessary information to process any claims and contact insurance plans on your behalf for services and procedures performed by Dr.Baker and her associates.
-Privacy practices are in place to ensure that your protected health information is only used to submit insurance information on your behalf, provide continuity of care with other providers and provide quality treatment. This information is otherwise confidential. You are permitted to have a copy of these policies at any time. The HIPAA policies of BFFSP has been adopted from the government policies detailed at aspe.hhs.gov.
-By signing below, you agree to obtain statements and payment information by text and/or email. You may opt out at any time by verbalizing this to BFFPS prior to your appointment.
-The request to complete ANY employer/FMLA/disability/lawyer paperwork is assigned a fee of $25 per incident. Excessive requests will be denied. This fee is at the doctor's discretion and may be changed based on time consumed and length of paperwork. **Please complete all fields possible including names, dates and addresses, phone and fax numbers**.

Signature of patient_____Date_____

Signature of financially responsible_____Date_____

☐ Check this box if you are signing on behalf of persons under 18 years of age to provide consent or are legal power of attorney to sign medical documentation on behalf of this patient.