

**FINANCIAL POLICY for WILLIAM F HINESER, DPM, PC  
FOOTHEALTH P.C.**

Thank you for choosing us as your foot and ankle healthcare provider. We are committed to the highest standards of excellence in your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we request you read and sign prior to any treatment.

All patients must complete our information forms before seeing the doctor in order to provide the best possible care.

**We accept Cash, Checks, Visa/Mastercard, Discover Card and for your convenience Care Credit**

**Regarding insurance plans where we are a participating provider:**

A valid insurance card must be presented at the time of service. All co-pays, co-insurance and deductibles are due at the time of treatment, before the patient is seen by the doctor. In the event that your insurance coverage changes to a non-participating plan (we participate in most plans) refer to the paragraph below. Undetermined deductibles are payable within 30 days of the insurance payment unless a payment plan is established and signed by the patient and our office.

**Regarding cash patients, indemnity (private) insurance, or insurance we do not participate with:**

We will be glad to bill your insurance for you. We are not required to accept the amount paid by your insurance company. We do require that at least \$50.00 of your bill be paid at each visit if owed. The balance is your responsibility whether your insurance company pays or not. The balance of payment is due within 30 days or a written payment arrangement must be made with our office. In plans with which we do not participate we are not a party to the insurance contract.

**Usual and customary rates and services:**

Our practice is committed to providing you with the best treatment, our charges are usual and customary for this area of the country. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If a service or procedure is provided and accepted by you, it is agreed that you are responsible for payment whether or not the insurance company determines it is a covered service, even if they decide not to pay for the service as part of our contract with the company. I understand that this policy supercedes any insurance contracts.

**Initial \_\_\_\_\_**

**Supply Items:**

Any supply items (creams, pads, etc) will be handled as self pay (cash) only. We do not bill insurance companies for these items as they are generally considered to be over the counter items. However, we will be happy to provide you with a receipt should you choose to bill your HSA account (Health Savings Account) for re-imbusement.

**Surgery Patients:**

We will verify coverage on surgery procedures for the patients convenience. After verification, deductibles, co-insurance, and co-pays and/or a deposit will be collected when the patient signs the consent form or surgery papers. Payment arrangements may be made on an individual basis.

**Minor Patients:**

Adults accompanying a minor and the patients (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by insurance coverage, to an approved credit plan such as Visa/Mastercard, Care Credit, or payment by cash or check at the time of service. Consent for treatment must be established.

**Cancelled or missed appointment:**

Please give us a courtesy call if you cannot make your scheduled appointment so that we can give it to someone else. Help us to serve you better by keeping appointment or rescheduling them. We do not charge for missed appointments at this time.

**Late fees:**

We reserve the right to charge a late fee in the amount of \$5.00 for every 30 days a payment is not made on your outstanding balance unless the claim is under insurance review.

**Work forms and reports:**

After the first two forms for each condition (course of treatment) have been filed we will charge \$5.00 for each additional form.

Thank you for reading and understanding our financial policy. Please let us know if you have any questions or concerns.

By signing below I agree that I have read and understand the Financial Policy and agree to it.

X \_\_\_\_\_ Date: \_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

X \_\_\_\_\_ Date: \_\_\_\_\_  
SIGNATURE OF CO-RESPONSIBLE PARTY