FINANCIAL POLICY FOR David Krausse DPM, LLC

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.

COPAYS. Co-pays are due at the time of service.

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

MEDICARE. We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. You are responsible for co-payment or deductible amounts as stated by Medicare and your secondary insurance company.

SECONDARY INSURANCE. 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.

REFERRALS/AUTHORIZATIONS. We are required to 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 this visit. If you do not have a referral from your primary care physician at the time of a visit, you be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

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 may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case to case basis. We accept the following payment methods: Cash or Check. An additional $25.00 will be added to your statement if the check is returned for insufficient funds.
In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* David Krausse DPM LLC for providing medical services to me or the below named patient. I agree to pay David Krausse DPM LLC any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if there is no health insurance coverage exists.

PRIVACY STATEMENT. Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **David Krausse DPM LLC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

PRINT Patient Name:_____ Signature:_____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name: _____ Signature:_____

Relationship to Patient:_____ Date:_____