The Family Footcare Center

PATIENT BILLLING POLICY

YOU ARE RESPONSIBLE FOR:

- Knowing what services are covered by your Insurance carrier
- Obtaining necessary referrals from your primary Care physician
- Knowing that The Family Footcare Center cannot honor a request from a patient to alter or change information on an insurance claim In order for the claim to be processed or paid
- Knowing that you are **ultimately** responsible for all charges
- **Presenting your insurance card(s) to the receptionist at every visit.**
- **The payment for services rendered to dependent children**

PAYING YOUR BILL:

- If you do not have insurance, you **must** pay at the time of service
- If The Family Footcare Center has not received payment From your insurance carrier(s) within 60 days, you are expected to pay the balance in full
- If you do not receive and Explanation of Benefits from your insurance carrier within 45 days, please contact your carrier
- **The Family Footcare bills your insurance carrier(s) as a courtesy**
- Overpayments in excess of $25.00 will be refunded within 30 days of your request
- The following payments are due on the date of service **Co-payments, Deductibles, Charges for Non-Covered services, and Outstanding debts**
- The Family Footcare center accepts: Cash, checks, major credit cards, debit cards, and Care Credit.

FAILURE TO PAY YOUR BILL MAY RESULT IN:

- **$30.00 service charge on returned checks**
- **$15.00 service charge for failure to pay your Copayment at the time of service**
- **Your Account being turned over to our outside Collection Company**
- **A bad credit rating**

The Family Footcare agrees to work with each patient to resolve outstanding patient balances. We offer automatic draft from your checking or savings account or we also offer Care Credit, you can apply online from your home or we can apply for you in the office.

By signing below I fully understand The Family Foot Care Center's Payment and Billing Policies and understand I am responsible for any and all services or products that I receive. I understand that in the event my insurance does not pay for any reason that it is my responsibility to pay any unpaid balances.

Patient Signature:_____ **Date:**_____

Witness:_____**Date:**_____