Financial Policy

Thank you for choosing ***Dr. Keith J. Kalish D.P.M., P.A.*** as your foot care specialist. We are committed to providing you a pleasant experience as well as the best medical care provided. Your clear understanding of our Financial Policy is important to our professional relationship and our billing staff is available to discuss our fees and this policy with you. We ask that all responsible parties read and sign our financial policy.

Required Information From You:

- New Patients must fill out and sign patient information forms prior to seeing the doctor.
- Patients must bring their insurance card(s) to each visit at our office.
- We will make a copy of your insurance card(s) as well as your driver's license or other form of identification with a photo ID (for identification purposes to prevent insurance fraud).
- We periodically may have you review information we have on file.

TO ASSURE YOUR INFORMATION IS ALWAYS CURRENT AND ACCURATE, PLEASE REPORT ANY CHANGES IN PERSONAL INFORMATION OR INSURANCE CHANGES.

Forms of Payment: We accept cash, check, Debit card, Visa, MasterCard, Discover, and Direct Debt.

Returned checks: There will be a $25.00 charge for all bank returned checks. If a second check is presented and returned from the bank, we will require future payments to be made by cash, credit card, debit card or direct debt.

Self Pay Patients: Payment is due at the time of service. All self pay patients who present without proof of insurance are required to pay for services at the time they are rendered.

Insurance Coverage: We make no claim to know what services your insurance plan covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by *your* insurance company representative is correct. It is your responsibility alone to know what services may or may not be covered by your insurance including any laboratory and diagnostic services that we provide. We encourage you to refer to your benefits manual if you have any questions regarding covered services. In addition, be aware that some and perhaps all of the services provided may be non covered services by your insurance. You will be responsible for payment of non covered services. In the event you provide us with incorrect insurance information that delays payment, you may be asked to pay billed charges in full and seek reimbursement from your insurance provider directly. All charges are your responsibility whether your insurance pays or denies.

Insurance Payments: This office will file your insurance claim as a courtesy. If any payment is made directly to you for services billed by Dr. Kalish, you recognize an obligation to promptly remit payment to us. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary charges". As your medical provider, we will only supply factual information to facilitate claim processing. If for any reason your insurance company does not pay within 90 days of the time of service, you will be responsible for the remaining balance.

Medicare: We accept Medicare assignment. We will submit your claim to Medicare but you will responsible for any deductibles, co-insurance or any charges not covered by Medicare. We will be happy to bill your secondary insurance if you provide us with the insurance information (copy of card). Any remaining balance will be billed to you and be your responsibility.

Have you met your $140.00 deductible for 2012?	YES	NO
Does your secondary insurance pay your Medicare deductible?	YES	NO
Does your secondary insurance pay the 20% not paid by Medicare?	YES	NO

Secondary Insurance: This office will file your secondary insurance as a courtesy. In the event that your secondary has not paid within 90 days of the date of service, payment for services becomes the patient's responsibility.

Non-Participating Insurance Plans or "Out of Network": As a service to our patients, we will bill your claim as a non-participating provider. All outstanding balances however are the responsibility of the patient. We cannot guarantee that your claim will be paid out of network. It is the patient's responsibility to determine if you have "out of network" benefits and it is the patient's responsibility to determine the amount of the "out of network" benefits, if any.

Workers Compensation: We do accept work related injuries as long has we have all of the needed information from the adjuster prior to the appointment.

Deductibles: If your deductible has not been met, per your insurance representative, you are required to pay for your visit at the time service is rendered.

Co-payments: Your insurance *requires* that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. Without it, you may be required to reschedule. Some insurance plans require you to pay a co-pay and a percentage other services (X-rays, injections, etc.).

Waiver of co-payments: The Office of the Inspector General strictly prohibits the waiver of co-payments.

Authorizations/Referrals: If your plan requires a prior authorization or a referral to see Dr. Kalish, it is *your* responsibility to obtain this prior to your appointment. If we do not have your authorization at the time of your appointment, you will either be responsible to pay or reschedule your appointment.

Financial Hardship/Payment Plans: Patients are expected to pay outstanding balances in full. However, payment plans may be accepted under certain circumstances with appropriate proof of documentation. Please contact our Billing Office (772) 567-0111 or 465-3207 to discuss this option if you cannot pay your balance in full.

Failure to pay: Any unpaid balances at the time of service will be subjected to a $10.00 monthly billing fee after 60 days. Then after 90 days from time of service unpaid balances will be sent to collections via IRS 1099-C form.

Patient Authorization

I have read, understand, and abide to the terms stipulated above. I have requested clarification of any part or parts of this financial agreement that I did not understand.

I request that payment of benefits be made to **Dr. Keith J. Kalish D.P.M, P.A.**

I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim.

I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be valid as the original. This authorization shall remain valid until revoked by me in writing.

Patient Name:_____

Patient Signature (or Parent of minor/Legal Guardian):_____

Date:_____

Name of person completing this form if other than patient:_____

Relationship to Patient:_____