J O H N F. T O R R E G R O S A, D. P. M., A. A. C. F. A. S.

A N K L E A N D F O O T S U R G E R Y

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Mail: P.O. Box 1199, Tavernier, Fl 33070

FINANCIAL RESPONSIBILITY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is an addendum to our existing Financial Policy, we require you to read and sign it prior to treatment.

All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND AMERICAN EXPRESS. WE OFFER EXTENDED PAYMENT PLANS (please consult with our Patient Accounts Representatives).

INSURANCE ASSIGNMENTS

In most cases we will accept assignment of insurance benefits. However, we do require a form of payment to cover amounts not paid by insurance. (Forms of payments include authorizations to pay by credit card, check or cash.) If your insurance company has not paid your account in full within 90 days of date of service we will automatically transfer your balance to your extended plan.

Payment in full is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and original claim form (when required). Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under Medicare and/or other medical insurance.

INSURANCE PLANS WHERE WE ARE A "PARTICIPATING PROVIDER"

All co-pays and deductibles are due on the date services are rendered, with the exceptions of Medicare, in which case we will bill once we receive the explanation of benefits from Medicare.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Unless canceled 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal

office visit. Please help us serve you better by keeping your appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read this Financial Policy and understand and agree with its terms.

Patient Name **Signature** **Date**