Accent Podiatry Associates

3050 S. Center Street, #140
Arlington, TX 76017
817-557-1006 (Phone)
817-557-2000 (Fax)

221 Regency Parkway, #140
Mansfield, TX 76063
817-477-3611 (Phone)
817-524-6677 (Fax)

800 Highlander Ave, # 400
Midlothian, TX 76065
817-987-1030 (Phone)

FINANCIAL POLICY

Thank you for choosing **Accent Podiatry Associates** as your foot and ankle specialty healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to ensure all your podiatric medical needs are met and to reduce confusion, our Billing Department and financial counselors are available to discuss our fees and this policy with you.

Health Plan Insurance: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment/co-insurance at the time of service. Our office's policy is to collect this co-payment/co-insurance when you arrive for your appointment.

HMO: The co-payment made at the front desk is for the **visit only** and often considered the time you spent with the physician. If an HMO patient follows the **referral or authorization guidelines** before their visit to a specialist, medical necessity and service is a covered service as determined by your health plan.

All Other Insurances: The co-payment made at the front desk is for the visit and for services indicated by your health plan. If you have any procedures performed during your visit to Accent Podiatry Associates, the **procedure co-payment, deductible and/or co-insurance will most likely not be covered as part of the co-payment made for your original visit that you paid at the front desk.** Unless otherwise stated by your health plan, all other insurances have co-payments and/or co-insurance, encounter fees, yearly deductibles, which must meet medical necessity and be a covered service.
In short, co-pays, co-insurance and deductibles are due when services are rendered.

Self-Pay Patients: As a self-pay patient, you will be asked to make payment for services rendered.

Minor Patients: For all services rendered to minor patients (under 18 years of age), we will expect that the parent or guardian accompany the minor or have a signed consent, which will acknowledge responsibility for payment for services rendered.

Miscellaneous:

1. You acknowledge that the insurance card and information provided each visit is the correct and current accurate information. You understand that it is your responsibility to inform Accent Podiatry Associates if a change in your health plan insurance occurs.

2. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We ask that you call your health plan to verify coverage of these services rendered. The customer service number is located on your health plan card. Accent Podiatry Associates will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office. To further clarify, please understand that should the Accent Podiatry Associates podiatric physician visit you in the hospital or perform surgery; that these physician fees are separate from the surgical assist, hospital facility, anesthesia, laboratory or pathology fees.

Additional Important Information:

1. Your insurance is a contract between you, your employer, and the 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 customary" charges. As your medical provider, we will only supply factual information to facilitate claim processing.

2. Fees for services, which include all unpaid balances, deductibles, and co-payments, care due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

3. All charges are your responsibility, whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty (60) days, you will be responsible for the balance in full. If any payment is made directly to you for services billed by Accent Podiatry Associates, you recognize an obligation to promptly remit payment to Accent Podiatry Associates.

4. I understand and agree that if I fail to make any of the payments, in a timely manner, for which I am responsible, after such default and upon referral to a collection agency or attorney by Accent Podiatry Associates, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

5. The above does not apply for those patients that are considered Workers' Compensation (WC). However, be advised that as a WC patient, you may be held responsible for charges in the event your claim is denied and all appeal processes have been adjudicated.

6. Durable Medical Equipment (DME) items such as walking boots, ankle braces: once DME is provided for treatment and removed from the office, it cannot be exchanged. Proper fitting will be determined on the day of the appointment. At Accent Podiatry Associates, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call 817-557-1006 (Press option #2 for the Central Business Office).

7. Over the counter medications, vitamins, medical supplies, pain relief creams, etc. are usually not covered under your health insurance plan. Therefore, payment will be required at the time of purchase.

Thank you for your cooperation.

Sincerely,
Central Business Office

PLEASE READ AND SIGN: *I certify that I have read and understand the above information to the best of my knowledge. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including fees above those designated as "usual and customary" by my insurance carrier. I agree that in the event of a dispute over fees or the collection of fees, the prevailing party shall be entitled, in addition to such other relief as granted, to be reimbursed by the losing party for all costs and expenses incurred thereby, including, but not limited to, reasonable attorney fees and costs.*

Patient's Name*:*

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Signature of patient (or parent if minor) ***Date***

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