BLOOMFIELD FOOT SPECIALISTS, LLC
705 BLOOMFIELD AVE., SUITE 201
BLOOMFIELD, CT 06002

FINANCIAL POLICY AGREEMENT

Patient Name: _____ Date of Birth: _____

CO-PAYS

All co-pays and past due balances are due and payable at the time of service unless prior arrangements have been made. Your insurance company requires us to collect your co-pay at the time of your visit. It is not our policy to bill you for your co-pay; if not paid at the time of service a $10 fee will be assessed. Payment may be made with cash, check, Visa or MasterCard. **We do not take Discover or American Express.**

REFERRALS

If your insurance company requires a referral be sure you request this from your primary doctor. If you are unsure if you need an insurance referral, call your insurance company. Please allow enough time for your primary care office to process the referral prior to your visit. **You will be responsible for any balance on claims denied due to no referral.**

SELF-PAY / NON-PARTICIPATING INSURANCE

Payment is required at the time of service.

DEDUCTIBLES

If you have an insurance plan with a deductible, your out of pocket expense will be due at time of service. Claim will still be submitted to your insurance for credit to your deductible.

RETURNED CHECK

You will be charged a $35 fee for any returned checks.

24 HOUR NOTICE IS REQUIRED TO CANCEL YOUR APPOINTMENT

Out of courtesy to our patients and for our practice, we ask that you give our office enough notice for canceling your appointment to avoid a **$50.00** no show charge fee for an office visit missed or **$50.00** no show charge fee for a consultation visit missed (New patient visit).

Patient Signature: _____ Date: _____/_____/_____

**** If not signed by patient, please indicate relationship to patient:**

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