AUSTIN PODIATRY PA

1221 Ben White Blvd Ste. 212B
Austin, Tx 78704
Phone (512) 448-3668
Fax (512) 448-4460

Office Insurance and Financial Policy

Our office believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and want you to completely understand our policy.

PAYMENT

Payment is expected at the time of your visit. This includes any **co-pays and/or non-covered charges from your insurance company**. We do ask for a copy of your insurance card and an ID or driver's license due to the many cases of identity theft. You are welcome to ask about our fees prior to your visit, but please realize that many fees are determined by the complexity of the patient's problem and insurance company. Thus we may not be able to state the exact amount of charges in advance, so that **in addition to the up front fees there may be a balance owing.**

Insurance

We are participating providers with many insurance plans. All services will be filed to those companies in which we participate with. Please remember that insurance is a contract between the patient and the insurance company thus **the patient is ultimately responsible for the allowable amount in full**.

Due to many insurance products, be sure to check with your benefits department on physicians and their services prior to your appointment. **In the event your insurance plan determines a service not to be covered, you will be responsible for the complete charge**. You are responsible for obtaining a properly dated referral if required, and responsible for payment if your claim rejects for lack of one.

Medical Records/Insurance Forms/FMLA

Copies of records or forms will be available for pick up **within 2 business days from the requesting time** along with a signed release authorization. Copies will **cost a minimum of $10.00 for the first 10 pages, and $1.00 for each additional page**. There will be a **$10.00 charge for each disability form**, FMLA or any other additional forms that may need to be completed or signed by our office staff or physician.

Patient's Printed Name: _____

I have read and understand the office policy stated above and I understand that I am financially responsible for all charges for services rendered on my behalf or on behalf of my dependent, whether or not they are covered by my insurance.

Signed:_____ Date:_____

I authorize the release of any medical information necessary to process any insurance claims, FMLA, or disability forms or letters. I authorize payment of medical benefits to Austin Podiatry PA. for all services provided.

Signed:_____ Date:_____