

Patient Financial Responsibility Policy

Thank you for choosing **Dr. Merrick Horn** for your **podiatric medical** care needs. We are committed to providing you with the highest quality care. Every patient must be thoroughly informed of their treatment options and the financial obligations for a particular service. Please carefully read and then sign this form to acknowledge your understanding of your financial obligations related to your treatment. If you should have any questions regarding our financial policies, please ask our **office staff** before signing this document.

The following is our payment policy, which we require you to read and sign prior to your visit(s).

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.

Patients have many different types of insurance and payment options for services rendered. To ensure that we have accurate information to process your claim, we will make a copy of your insurance identification card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or insurance information. Patients without insurance are required to pay in full at the time of service.

Participating Plans: You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit your **medical** claim directly to your insurance company for payment on your behalf. Full payment at the time of service is expected for all patients without insurance or those covered under plans which we do not participate in.

Non-Covered Services: If your provider does not participate in your insurance plan or your services are not covered by your insurance plan, you are responsible for payment of all charges at the time of service. We can submit the claim directly to your carrier, or a claim can be mailed to you.

Copayments or Deductibles: If your doctor waives your copayment or deductible, he/she is in effect giving you a discount. Therefore, if he/she is willing to provide this service to you at a discount, he/she must disclose this to your insurer and give the same discount to them. **All co-pays, deductibles, and non-covered services will be collected at the time of service.**

Nonpayment: If your account is over **45** days past due, you will receive a letter stating that you have **15** days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative **medical** care. During those 30 days, we will only be able to treat you on an emergency basis.

Payment: For your convenience, the following payment methods are accepted cash, personal check, Visa, MasterCard, and Discover.

I authorize payments to be made directly to the **Dr. Merrick Horn** and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my **medical** insurance claims. I have read the "Financial Policy"; I understand and agree with it. By my signature below, I hereby authorize the assignment of financial benefits directly to **Dr. Merrick Horn / Drs. Horn & Horn, PA** for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Policy:

Print Name of Patient or Responsible Party

Signature of Patient or Responsible Party

Today's Date: _____