Bellevue Podiatric Physicians 1609 116th Ave. NE Bellevue, WA. 98004

FINANCIAL POLICY ASSIGNMENT OF BENEFITS AND HIPAA AGREEMENT

- ☑ I agree to the below terms and conditions.
- ☑ I give permission to Bellevue Podiatric Physicians' staff to leave a detailed voice message to the phone number(s) on file.
- ☑ I acknowledge that I will be provided a copy of the privacy policies (HIPAA) notice upon request.
- ☑ I understand that if I do not give a 24 hour cancellation notice that I will be charged a $50 no show fee.

CO-PAYS AND UNPAID BALANCES DUE AT TIME OF VISIT: Please be prepared to pay any co-payment and outstanding balances (partial or full) at the time of service.

CREDIT/DEBIT CARD ON FILE: We require a credit or debit card on file to reschedule a no-show appointment.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have complete and accurate insurance information and a copy of your identification card for claim form.Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **It is your responsibility to contact your insurance company regarding preauthorizations, obtaining required referrals, second opinions, etc.** Failure to do so may reduce the amount of benefits paid by your insurance and the palance will then become your responsibility to pay.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment.

SUPPLIES AND DURABLE MEDICAL EQUIPMENT: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of service and items are not refundable once the merchandise leaves our building.

ASSIGNMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductible, unpaid balances, and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)

PICTURE TAKEN: It is our policy to add a patient photo to each patient chart, you may decline.

COLLECTION NOTICE: Any unpaid balance surpassing a period of 6 months will be subject to collections.

I have read and agree to the terms set forth in the above financial policy. I understand I am financially responsible for any balance due. I agree to make all payments for any co-payments, charges due within my current deductible and any unpaid balance from previous visits. I agree to the assignment of benefits.

Patient Name:_____**Date:**_____

Patient or Guardian Signature: _____ **Date:** _____