

LONE STAR PODIATRY
DR. ANDREW CASSIDY

Financial Policy: The following is a statement of our financial policy, which we require you to read and sign prior to treatment. Payment is due at time of service. We accept cash, checks, Visa/MasterCard, American Express, and Discover. We accept assignment of insurance/Medicare benefits. However, we do require that all deductibles, co-insurance and co-payments be paid at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We get a brief summary of your benefits prior to your first appointment. The benefits we receive are only a summary of benefits and not a guarantee of payment. If something happens to not be covered by your plan, you are responsible for the payment in full. This includes instances where the information conflicts what benefits that were given to us by your insurance company.

Managed Care Plan: If you are a member of a Health Maintenance Organization, (HMO) or other managed care plan, in most cases your payment to us is limited to a co-payment. Your coverage may be limited though, and may not include items such as orthotics, casting supplies or other equipment. Should you and the doctor decide to proceed with these services, this will be an out of pocket expense and will be payable at the time of service. Your plan may also require that you obtain your x-rays and laboratory services from a facility other than Lone Star Podiatry.

Private Insurance: If you have private health insurance, we will be happy to file your insurance claim in lieu of full payment at the time of service. You will be asked to pay only the amounts not covered by your insurance (such as deductibles, co-insurance and non-covered services) at the time services are rendered, if, for any reason, your insurance company has not paid the balance within 60 days from the date of service, the balance will automatically be billed to you for full payment. Once the insurance claim is paid in full, other charges such as coinsurance, etc. will be billed directly to you. I also understand that if the patient portion is not paid in full in a timely manner, an additional late fee of \$25.00 will apply.

Medicare: We accept Medicare's allowable as full payment. We will file your claim with Medicare. You will be required to make payment at the time of service for your co-insurance amount (20% of allowable) and for any portion of your deductible which has not been met. Please be aware that some and perhaps all of the services (I.E. orthotics, routine foot care) provided may be non-covered services under Medicare program and or other medical insurance. You will be responsible for payment of not-covered services at the time they are rendered.

Erisa: I assign the right to payment for all medical benefits directly to Lone Star Podiatry in consideration for medical services and supplies provided pursuant to my health insurance plan. In the event my health insurance plan refuses to pay for provided medically necessary services, I also assign all my ERISA rights to the doctors with in the Lone Star Podiatry practice for a full and fair review of any and all claims processing. This ERISA assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of the doctors who make up the Lone Star Podiatry Practice to see patients including myself, on an insurance assignment basis. I understand that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services.

Assignment of Benefits: In the event that services rendered are not paid for by the responsible party, I hereby give authorization for payment of insurance benefits to be made directly to Lone Star Podiatry, Dr. Andrew Cassidy, P.A., and any assisting providers for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____

Date: _____