North Eastern Ohio Podiatry Group, LLC
FINANCIAL POLICY
440-953-3668

1. It is your responsibility to present **your insurance ID card and a photo ID at the time of your visit**. In accordance with your insurance company's member handbook, it is your responsibility to **provide accurate insurance information – at the time of each visit**.
2. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing statement so that you can attempt to obtain reimbursement from your insurance company.
3. It is your responsibility to ensure that our physicians are in your insurance network.
4. If your insurance plan requires a referral, it is your responsibility to obtain this prior to being seen by our physicians. If this referral is not obtained and your claim is denied, the unpaid balance will be your financial responsibility.
5. **All co-payments are due at the time of visit.** Post-dated checks are not accepted.
6. **The fee for a returned check is $60.00.**
7. Once benefits are verified and your financial responsibility is calculated, you will be notified of your payment amount and due date. After you have been notified of the said amount, **all balances are due PRIOR to any further office visits, procedures, or surgeries**.
8. Payment is due for rendered services 10 days from receipt of your billing statement. Unpaid balances must be paid in full prior to any additional visits unless arrangements have been made with our Practice/ financial counselor.
9. The billing department will send out statements for any unpaid balances. Each additional statement, after the first one, will be charged a $20 processing fee and that fee will subsequently be added to your current balance.
10. You are ultimately responsible for payment of charges for services you receive from a North Eastern Ohio Podiatry Group, LLC/ Sole Perfection Physician.
11. Cancellations for any scheduled appointment or procedure must be received at least 24 hours prior to the scheduled appointment. **Patients who fail to keep and/ or cancel a scheduled appointment may be charged a $50.00 No Show Fee.**
12. **We reserve the right to not schedule a patient in the future at all - after 2 consecutive no-shows or if multiple no shows occur.**
13. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date. There is a **$100.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days** from the date of the surgery unless cancellation is due to insurance denial or medical necessity.
14. Patients who fail to keep their surgery appointment will be subject to a **$300.00 surgery No Show Fee.**
15. Medical record requests must be received in writing and at least 3 business days or 72 hours, whichever is greater, prior to the date needed. No fee will be charged to a patient requesting their medical record copy sent directly to another provider. Any other requests for medical records are subject to a fee according to State of Ohio law. Fees must be received prior to the records delivery. Medical records will be sent to the authorized address. An official records release form must be signed by the patient prior to release of the records. Separate fees would be charged for copying Radiology images produced on our local office equipment, using our Practice' own media.
16. **Expediting requests for records/ images is subject to additional fees of $50.00 to produce copies within 1 business day.**

17. Administrative Services: There is a $25.00 charge for each required Administrative Service payable prior to service completion. This Administrative Service Fee covers specific administrative services including, but not limited to: forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-brand formulary drugs, letters for employers, school, health clubs and any other administrative items not covered by insurance.
18. During your care, some outside diagnostic services or additional durable medical equipment may be required. The provider of these services will bill your insurance company separately and you will be responsible for all charges as determined by your insurance company policy to these individuals. North Eastern Ohio Podiatry Group, LLC / Sole Perfection does not have any responsibility for those services or fees.
19. Please be advised that our Practice is an independent podiatric medical practice, not bound by/ subject to any HCAP or similar agreements that might be in place for patients receiving services in Hospitals, and other facilities. As a result, **the HCAP patients** referred to us by those facilities **should expect to be charged and pay for our services according to the self-pay fee schedule**.
20. Visits involving work related injuries require detailed information on injured patient's BWC claim numbers/ proper referrals/ records release authorizations/ employer information/ employment status/ job duties/ footwear requirements/ legal representative name and contact information (if retained one).
21. Visits involving liability insurance / motor vehicle accident insurance require the insurance information as well as the name and contact information of the legal representative (if retained one).
22. Due to the lengthy process of authorizing the durable medical equipment items by health plans, ordering custom items, scheduling their pickup by patients – we require a $100.00 deposit ahead of ordering the said items from our vendors. The prior authorization process may take up to 3-4 weeks. The deposit amount is refundable subject to the insurance allowed amount and coverage. Since the items are billed to the insurance if and when they are picked up by patients, the deposit becomes non-refundable if the item is not picked up within 30 days of our receipt of the item.
23. I also agree to treat all physicians, staff and fellow patients with dignity and respect.
24. To the best of my knowledge, I have answered the questions on the intake forms accurately. I understand that providing incorrect information could be dangerous to Patient's health. I understand that it is my responsibility to update this office on any changes in the future.

I acknowledge that I was provided with a copy of the **Notice of Privacy Practices** and a copy of **Financial Policy** and that I have read (or had the opportunity to read if I so chose) and understood the above-mentioned documents

_____ _____

Patient name (please print) Date

_____

Authorized Representative/ POA/ Legal Guardian (if applicable) – print name

_____

Signature