OUR FINANCIAL POLICY

You must notify us of any change in your address, phone number and insurance information.
COPAYMENTS - We are required to collect your copay at the time of service. Please be prepared to pay at each visit.

ADMINISTRATIVE CHARGE - Patients will be billed a $10.00 billing charge if applicable payment (including copay) is not made at the time of service.

★ **MISSED APPOINTMENTS** - If unable to keep an appointment a 24 hr. notice is mandated. Failure do to so will incur a charge (Regular Appt. $85.00) - (Extended Appt.$125.00). We reserve the right to dismiss any New or Existing patient from our office that is NO SHOW for their appointment.

REFERRALS - If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral you will be required to sign a financial waiver making you responsible for your bill or your appointment will have to be rescheduled.

SELF PAY AND NON PARTICIPATING PLANS - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier who will reimburse you directly.

MEDICARE - We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance provided there is no secondary insurance coverage.
PRIVACY NOTICE It is our intent in this office to treat you professionally and provide the best foot care possible. During the course of your treatment it may be necessary for us to share information (both medical and personal) about you with other professionals within and outside of our office. In some instances information may be sent out of this office for transcription purposes. We will share this data only when necessary and will keep it in strict confidence to protect your identity.

We accept CASH, CHECK,DEBIT CARD, HSA,FSA, MASTERCARD, VISA, AND DISCOVER
Thank you for taking time to review our policies. Please feel free to ask any questions or share with us special concerns.
[ ] **PLEASE CHECK: I AUTHORIZE THE OFFICE TO LEAVE PHONE MESSAGES RELATIVE TO MY CARE**
RESPONSIBLE PARTY
SIGNATURE:_____ DATE: _____

STAMFORD PODIATRY GROUP, P.C.

1234 SUMMER STREET SUITE 202 STAMFORD, CT 06905

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TELEPHONE: 203 323 1171
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Dear Patient:

In effort of provide you with flexible payment arrangements, we have expanded our payment policy.

Payment arrangements are requested at the time of your visit. .

Our office is a fully equipped and accredited user of most major credit card companies which will enable you to use your credit card to automatically cover amounts not paid by your insurance company. Please read and sign the following:

I authorize Stamford Podiatry Group, PC to keep my signature on file and to charge my credit card account as indicated below.

Balances of charges not paid within 90 days.

Balances for deductibles not paid within 90 days.

We accept: _____ Visa _____ Mastercard _____Discover ___ Health Savings Acct.

Patient
Name:_____

Credit Card Number_____Exp.Date_____

_____

Patient/Cardholder Signature Date