GERALD B MCCOOL, DPM

PATIENT FINANCIAL POLICY Patient Acct #_____

Thank you for choosing Dr. Gerald McCool for your care. If you have any questions regarding the following, please ask the receptionist or Office Manager.

SUBMISSION OF INSURANCE CLAIMS: YOUR HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR HEALTH INSURANCE PLAN. You are responsible for understanding and following your health plan's required procedure and policies. It is your responsibility to provide us with ACCURATE AND UP-TO-DATE INSURANCE INFORMATION, so we can appropriately file an insurance claim on your behalf for services rendered. If we DO NOT receive payment within 60 days from the date of service you have encountered, you are responsible for the unpaid balance and we may request immediate payment from you. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," (Medicare Patients will sign an ABN form at time of service) you will be responsible for the complete charge. It is your responsibility to contact your health plan regarding benefits or coverage issues.

REFERRALS AND AUTHORIZATIONS: If your health plans requires you to have a referral authorization from your PRIMARY CARE PHYSICIAN (PCP) in order to be seen by Dr McCool, it is YOUR RESPONSIBILITY to verify that a referral has been received by our office prior to your visit. FAILURE TO HAVE A VALID REFERRAL AUTHORIZATION MAY RESULT IN RESCHEDULING YOUR APPOINTMENT UNTIL A VALID REFERRAL IS OBTAINED. If you request to been seen WITHOUT a valid referral, you will be responsible for payment of services rendered and will need to complete additional paperwork that will allow us to collect full payment at time of services rendered. If your health plan requires surgery or other services to be pre-authorized, please notify the receptionist as soon as possible so we can help and obtain a pre-authorization for your surgery or services. Pre-authorization or health benefit coverage does not guarantee payment for your services rendered. If payment is denied, you may be responsible for payment of the balance in full. If you have questions regarding referrals and authorizations, feel free ask the receptionist or Office Manager.

CO-PAYMENTS, CO-INSURANCES, DEDCUTIBLES, NON-COVERED SERICES, AND PRIVATE PAY: If your health plan requires a co-payment, co-insurance or deductible that apply to you at time of service, you will be required to pay before seen or after check-out once services are rendered. Private pay patients will be required to pay in full before being seen or after services are rendered. For your convenience we accept cash, personal or cashiers checks, debit, major credit cards, and Health Savings Account (HAS) debit cards. There will be a $50.00 fee for returned checks and you will have 14 days to clear your balance personally at the office, CASH ONLY. Over 14 days we will forward your insufficient check to the County Attorney for collections.

NO-SHOW APPOINTMENTS, SURGERY CANCELLATIONS: Should you NOT show up to your next given office appointment, there will be an automatic $25.00 no-show fee. Cancellations are accepted greater than 24 hours in advance. We are NOT responsible to remind you of your next appointment. Should you elect to cancel your scheduled out-patient surgery, we require 7 business days advance notice. Failure to notify us within this time will result a $200.00 out-pt non-cancellation fee. If you are 15 minutes late, or don't notify the staff you're running late, your appointment may be rescheduled.

PATIENT RESPONSIBILITY FOR BILLED AMOUNTS: We will send you a statement of any remaining balance on your account after health plan payment are applied. Payment is due in full within 30 days from the date that appears on your billing statement. If we do not receive payment from you with 30 days, we will attempt to contact you for your payment. If we receive no further response within the next 30 days, your account will be turned over to our collection agency. IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND LEGAL FEES INCUURED.

MINORS: A parent or legal guardian must accompany a minor and consent to treatment. Parents and legal guardians must comply with the terms of this financial policy. The parent or legal guardian that accompanies the minor will be held responsible for payment at time of services rendered.

MISSING, INACCURATE OR INCOMPLETE BILLING INFORMATION: You are responsible for notifying our office of any health plan or billing information changes. Failure to notify us of changes may result in you being responsible for any remaining balance on your account. Dr. McCool's practice will not be responsible for any billing errors, lack of coverage or payment due as a result of missing, inaccurate, or incomplete information that you have provided us, including inaccurate information on secondary payment coverage.

I HAVE READ AND UNDERSTAND THE "PATIENT FINANCIAL POLICY" FOR GERALD B MCCOOL, DPM AND ACCEPT ALL THE TERMS AND CONDITIONS AS STATED ABOVE. IF I CHOOSE TO ASK FOR A COPY OF THIS POLICY, I WILL NOTIFY THE FRONT DESK.

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian _____ Relationship to Patient: _____