



Thomas A. LeBeau, DPM, FACCS

OUR FINANCIAL POLICY

Welcome to our office. We are committed to providing you with the best possible care. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

We accept cash, checks, and major credit cards.

INSURANCES

If you have insurance, we will do all we can to help you receive maximum benefits.

INSURANCE PATIENTS PLEASE READ CAREFULLY: The percentage of coverage by your insurance company may be based on **your insurance company's own reduced fee schedule for medical services** and may be less than actual charges, resulting in lower coverage for you. We have no control over this situation. **Lower payment is a direct result of the plan selected by your employer. Please be advised that WE CANNOT WAIVE CO-PAYMENT. We are REQUIRED BY LAW TO COLLECT CO-PAYMENT.**

MEDICARE PATIENTS: This office accepts Medicare assignment. Medicare patients are fully responsible, however, for the initial yearly deductible and the 20% co-payment. This payment is to be made at the time services are rendered.

MEDICAL RECORDS, RELEASES, AND INSURANCE ASSIGNMENTS

I request and authorize Dr. LeBeau or assistants of their choice to perform podiatric medical treatment. I also authorize the taking of photographs for medical use by this office.

I permit a copy of these authorizations and assignments to be used in place of this original, which is on file at the physician's office.

PHYSICIAN INSURANCE ASSIGNMENT – I authorize payment directly to Thomas LeBeau, DPM for surgical and/or medical benefits. Any services for which assignment is not accepted are acknowledged to be my full and complete financial responsibility. **MEDICARE/MEDICAID** – I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct.

RESPONSIBILITY FOR ACCOUNT – I agree that should the amount of insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services rendered if the expense is not covered by my insurance.

COLLECTION INFORMATION – I understand that my portion of all fees is due at the time treated unless previous arrangements have been made. I will be billed for my portion of any fees not paid at the time of service. Any amounts which are 90 days past due will be eligible to be turned over to a collection agency, unless previous arrangements have been made. Collection Agency fees are recognized to be my (the patient's) responsibility. There will be a \$20.00 charge for any returned check.

We know at times patients do not have any insurance. If this is the case, the procedure and cost will be discussed prior to service. At this time, a payment plan will be set up. Please make sure to set up these arrangements prior to service.

NOTE: We do use other facilities such as hospitals, laboratories, etc., for blood work and cultures. Therefore, you may receive billing information from these facilities.

Thank you for understanding our Financial Policy. We are here to help you. Please let us know if you have any questions or concerns.

Patient Signature: _____

Responsible Party Signature: _____

Date: _____