Financial Policy

In order to achieve our goal of providing you with the best possible care, we need your assistance and understanding of our financial policy:

Appointments:

- Please arrive for your appointment 15 minutes early.
- It is your responsibility to verify that we are currently under contract with your insurance plan and that you have obtained all of the necessary referrals before your scheduled appointment. Please call our office for necessary provider ID's needed. Failure to do so may result in your appointment being rescheduled.
- Please inform the receptionist of any changes to your demographic information (insurance, address, phone numbers etc.)Failure to notify us immediately of changes in demographic information, financial status and /or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

Missed or Cancelled Appointment:

- If you are more than 15 minutes late for an appointment it may result in your appointment being rescheduled, we ask you notify us as soon as you can.

"In Network" vs. "Out of Network" Insurance:

- Your insurance coverage and benefits are a contract between you and your insurance company. Therefore all disputes must be handled between you and your insurance company.
- While we make every effort to assist you with your insurance questions and submissions, you must understand that it is YOUR responsibility to verify your insurance coverage and to understand the extent of that coverage.
- Insurance companies are obligated to YOU, THE INSURED, and not our office. It is often difficult or impossible for us to get information regarding your insurance.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a self pay patient.

Medicare Patients: Please make sure you have a full understanding of your benefits and what might be your responsibility if not covered by you insurance plan.

Payment is due at the time services are rendered:

- Co-pays and all non-covered items and charges are the insured/patients financial responsibility and are due at time of visit.
- Any outstanding balance may incur a monthly statement processing fee, in addition to the initial balance.

Self Pay Patients:

- We try to be very understanding of our cash paying patients. All fees will be due at the time services are rendered. Our staff will be able to give you an estimate of your appointment fees, but please keep in mind it is often impossible for us to quote what will be done at your appointment.

Additional Paperwork:

- Any paperwork needed to be filled out by our physicians or staff will result in a $5, $10 or $15 charge, depending on the length of the paperwork.
- A 48 hour notice is REQUIRED for all paperwork.

Lab/Hospital Charges

- Any service provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice.
- It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an explanation of benefits (EOB) from your insurance carrier.

Patient Consent:

By signing this document below, I acknowledge that I have received professional medical services from Dr Ali Albert Anaim /Comprehensive Foot &Ankle Center of Collegeville. I authorize the release of any medical information necessary to process Dr. Anaim's claim for services performed. I authorize payment of my Insurance carrier, government/medical benefits to Dr. Anaim. I understand and consent to CFAACC financial policy. I will cooperate with the billing department to ensure payment for my services. I understand that I will be responsible for any costs associated with the collection of my account should I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

___________________________________ ________________________________ Date __/__/___

Printed name of patient/mother /father/guardian Signature of patient/mother/father/guardian

Things to bring with you: Health Insurance Cards, Driver's License, Method of Payment, Xrays,CT's,MRI's related to visit

For your convenience, we accept Visa, MasterCard, Discover and Flexible Spending Account debit cards