Lansdowne Foot & Ankle Center
19440 Golf Vista Plaza, Suite 120
Lansdowne, VA 20176
Phone: (703) 858-7887

INSURANCE AND FINANCIAL POLICY

Due to the increased costs associated with medical billing, it is necessary to clarify our financial policy to help maintain reasonable fees, and continue to provide the quality of care you deserve. Please understand that we participate with many health plans. We cannot be aware of each patient's benefits under their particular plan. In addition some services or supplies, although deemed medically necessary by the doctor, may not be a covered under your particular plan**. IN ALL CASES, PAYMENT OF PROFESSIONAL FEES, DURABLE MEDICAL EQUIPMENT AND SUPPLIES ARE THE RESPONSIBILITY OF THE PATIENT, SPOUSE, PARENT OR GUARDIAN.**

- We are a participating provider with most local PPO's, HMO's, and Medicare. This means that we accept assignment for these plans. If you do not have health insurance, or have a health plan in which we do not participate, payment is expected in full at the time of service.
- As a service to you, we will be glad to submit the necessary forms directly to your primary insurance plan. However, **we do not submit to secondary insurances** unless mandated by any contract we have with the plan.
- If we participate with your health plan, a co-pay or deductible is required at the time of service for all visits. A $10.00 rebilling fee will be charged to you if your copay is not made at the time of service.
- Virginia law (Fair Business Practice Act) mandates that insurance companies pay all clean claims within 40 days of submission. If claims are not paid in this time, the patient will be responsible for all charges.
- A 50% deposit is required on all custom orthotics or braces, with full payment due upon delivery of item or items. Custom devices may not be returned (we will do our very best to have the devices adjusted to assure a comfortable fit).
- Late Payments: Rebilling fees (no charge if paid in 30 days from billing date) may be added if payment is not made within 30 days. A $10.00 rebilling fee will be added to balances more than 30 days past due and an additional $10.00 rebilling fee will be added to subsequent bills until the delinquency is paid.
- The responsible party agrees to pay all collection fees incurred including but not limited to legal expenses, fees to collection agencies, all court related costs, service, filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debt on accounts with the practice of Gary Kugler, D.P.M. and Lansdowne Foot & Ankle Center.
- Other miscellaneous Fees (Not covered by insurance): 1. Appointments not canceled within 24 hour ($25.00). 2. Returned Check Fee ($25.00). 3. Completion of forms/letters unrelated to reimbursement by the participating health plan such as disability forms, treatment summary, etc. ($25.00 minimum). 4. Medical record copying/transferring (variable).

We will do our very best to assist you with your insurance or other billing/payment issues. We also expect your cooperation to assist us with any issues associated with your insurance plan to insure prompt payment. Our office accepts checks, cash and credit cards. If you have any questions please call our office at (703) 858-7887.

I, hereby, authorize payment directly to **Lansdowne Foot & Ankle Center** of benefits otherwise payable to me. I authorize the release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I agree to be responsible for payment of all services rendered or supplies dispensed, on my behalf or on behalf of my dependents. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original.

I have read and fully understand this financial policy. I agree to payment in full or any required co-payments upon services

rendered, unless other arrangements have been made.

_____ _____

Signature of Patient or Responsible Party Date

_____

Please Print Full Name / Relationship to Patient

Lansdowne Foot & Ankle Center

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

(*complete the following section only if you wish to allow additional access to your personal health information*)

I authorize the following person(s) access to my protected health information (PHI)

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature