Payment Policies

_____Initial I_____ authorize Housatonic Valley Podiatric Center LLC to contact me by telephone, cell phone, text and email with medical information pertaining to my care. If I am unavailable, this authorization gives Housatonic Valley Podiatric Center LLC permission to leave this information on an answering machine at the following phone number :_(_____)_____ .

_____Initial I authorize Housatonic Valley Podiatric Center LLC to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment.

_____Initial Insurance Information: Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____Initial Account Balances: When Insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. You are responsible for payment of services unpaid by your insurance company and for timely payment of your account. Housatonic Valley Podiatric Center LLC reserves the right to reschedule or future appointments for delinquent accounts.

_____Initial Co-payments: are expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional $10 fee. Housatonic Valley Podiatric Center LLC accepts cash or major credit card as a form of payment. We do not accept personal checks.

_____Initial Self pay: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

_____Initial Referrals: If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements.

_____Initial No shows: A $50 no show fee will be assessed for all visits not previously cancelled within 48 hours.

My signature below indicates that I have provided accurate information to the best of my knowledge and I understand and agree to the provisions above.

Signature of Patient / Legal Representative _____ Date_____/_____/20_____

A copy of this form can be found at
www.Housatonicvalleypodiatriccenter.com

Patient Name:_____ Patient#:_____