

MARYLAND PODIATRY CENTER

FINANCIAL POLICY

Thank you for choosing our office to provide you with your foot and ankle needs. Our commitment to you will hopefully meet your expectations. The services provided by the office necessitate a financial responsibility from our patients. The following summarizes the financial areas of concern.

CO-PAYS: These payments will be collected each visit prior to being seen.

SELF PAY: If health insurance is not available, payment will be expected in full the day of service.

MEDICARE: The office participates with Medicare and the bill will be submitted for you, any co-pay or deductible will be the patient's responsibility, as stated by Medicare and secondary insurance.

SECONDARY INSURANCE: After payment from primary insurance is received, the secondary insurance company will be billed, as necessary.

REFERRALS/AUTHORIZATIONS: It is a legal agreement that we follow the guidelines of your insurance company. If you need a referral to be seen by a specialist, then it is your responsibility, not this office, to have it available the date of your visit. If a referral, which is required to be seen, is not present at the time of your visit, then the financial responsibility for services delivered will be placed on the patient. You have the option of rescheduling your appointment to a later date.

PATIENT BILLING: Please let the office know of any hardship you may have with payment of your bill. After the third notice to collect your responsibility of payment after the primary insurance and secondary insurance (if applicable) the account will be forwarded to a collection agency. Any returned checks will result in \$30.00 added to your statement. Methods of payment include cash or check.

PRIVACY STATEMENT

Any information disclosed in your records will remain confidential and will not be used for any reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

I have read the above policy regarding my financial responsibility to John Murphy, DPM LLC for providing medical services to me or the below named patient. I agree to pay any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if no health insurance exists.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with my insurance company as presented and assign directly to John Murphy, DPM LLC all insurance benefits payable to me for services rendered. I understand that I am responsible for all co pays, deductibles, and non covered services. I hereby, authorize the doctor to release all information necessary to secure payment of benefits. I authorize **release of medical information** to my insurance carrier or requested physician to provide continuity of care. I authorize this signature on all insurance submissions.

I understand it is my responsibility to inform my doctor of any change in my health insurance information.

Patient Name: _____
Please Print *Signature* *Date*

FINANCIAL RESPONSIBLE PARTY:

NAME: _____
Please Print *Signature* *Date*

Relationship to Patient: _____

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