Dr. Jill Hagen Dr. Lauren Grossman
PODIATRISTS
363 GRAND AVENUE • ENGLEWOOD, NJ 07631
(201)568-6977

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **FINANCIAL POLICY** which we require you to read and sign prior to initial treatment.

- **ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM BEFORE SEEING THE DOCTOR.**

- **WE ACCEPT CASH, CHECKS OR MASTERCARD/VISA.**

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. **We are not a party of that contract.** Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and other medical insurance programs. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **You are responsible for all non-covered services, deductible, copays, and coinsurance.**

ADULT PATIENTS AND MINOR PATIENTS: Adult patients (18 or older) are responsible for payment.

The adult accompanying the minor and the parents (or guardian of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless payment by Cash, Check, MASTERCARD or VISA at the time of service has been verified.

PATIENT LIABILITY: If this account is assigned to an attorney for collection and/or suit, I shall pay 33 1/3% of the claim as payment for attorney's fees and cost of collection.

CHECK RETURN POLICY: For any check that is returned from the bank there will be a service charge of $30.00 that must be paid to Podiatry Associates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

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Signature of Patient or Responsible Party Date

_____ _____

Signature of Co-Insurance Responsible Party Date