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Self-Pay Financial Policy for Varni Foot and Ankle Care, PLLC

Thank you for choosing **Varni Foot and Ankle Care** as your health care provider. Please carefully read and **Initial** each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients regardless of financial status. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

Self-pay patients are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us.

____ 1. I am expected to pay in full at time of service. If you have an insurance plan that the office is not contracted with, we can provide you with all the necessary information for you to file a claim with your insurance company. Please ask the office staff for this when you check out.

_____ 2. I understand that **Varni Foot and Ankle Care** will collect all payments at the time of visit and any procedures amount equal to payment in full for the planned procedure code. Payment responsibility is determined by agreement between you and **Varni Foot and Ankle Care.**

Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

_____ 3. I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

_____ 4. I understand that if I am unable to make a scheduled appointment, I need to contact **Varni Foot and Ankle Care** at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE MAYBE BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24 HOUR ADVANCED NOTICE.

_____ 5. I understand that if my accounts not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

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Full Name of Patient or Authorized Representative	**Signature**	**Date**

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Relationship to Patient