Account #

_____

SPOKANE FOOT CLINIC/NORTHWEST SURGERY CENTER FINANCIAL POLICIES

At the SFC / NWSC, we are committed to providing you with the best care possible. We are also here to assist you in any way we can to answer questions or concerns regarding your clinic account. If you have medical insurance, we will help you receive your maximum allowable benefits, as different insurances vary quite considerably, depending on one's individual contract. We must emphasize that as a medical provider, our relationship is with you; not your insurance company. Therefore, it will ultimately be your responsibility to familiarize yourself with the rules which apply to your contract, and to insure that your clinic account is paid. Co-pays are due **prior** to seeing your doctor on the day of your visit. We accept cash, check, MasterCard, Visa, American Express and Care Credit for all of your payment needs. If your insurance does not pay for the services provided, and/or it is a service requested by you, a release of liability waiver must be signed by you in advance to insure your payment. We realize that rare, or temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Other things you will need to understand as part of our financial policies:

- If a referral is required by your insurance, it is **your** responsibility to make sure that a current referral has been obtained by our clinic for your care **prior** to your appointment. If no referral has been obtained, your appointment may need to be rescheduled until you have a current referral.
- We will need a copy of your **current** insurance card to bill for your visit. Please bring your insurance card with you, including any supplemental insurance information, and notify our front desk if your address / contact information has changed since the time of your last visit. You will be billed for any remaining balance after your insurance plans have processed the charges.
- Be aware that benefits may vary if we are "out of network" for your particular insurance.
- There will be a $30 charge for any returned check.
- An annual interest rate of 15% (1.25% monthly) will be assessed to your unpaid balance after 60 days.
- If your account is ever referred for collection, there will be a $30 non-refundable collection fee. If necessary, there will be additional charges for court, collections agency, and attorney fees.
- We reserve the right to charge for copying of medical records in accordance with Washington State Law.
- Cash Pay patients: Option 1: A 20% discount for payment in full on day of service or
  Option 2: Payment of 50% of your total bill for the day is due at the time of service and payment arrangements must be made on remaining balance. **No discount is offered on this option**.
- Workers Compensation patients: Please bring your claim number, date of injury, and mailing address of where we are to bill. We also need to know if you have any additional private insurance coverage. Please bring this insurance card with you to your appointment.
- Motor Vehicle Injury patients: We will bill your own car insurance company for you if you have PIP coverage. We will need to know if you have medical insurance in the event that the PIP is exhausted. It is our policy not to wait for settlement for payment of our services.

Insurance Release and Lifetime Authorization Statement:

"I, the undersigned, acknowledge that I have read the policy and that I agree to the policy therein. If I have medical insurance, I authorize payment of medical benefits directly to Spokane Foot Clinic / Northwest Surgery Center for any services furnished to me by the physician at either of these two facilities. I also authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits. I understand that I am financially responsible for any amount not covered by my contract, and it is my responsibility to know what my insurance company covers and / or requires for pre-authorization of services, payment, or delivered services, as well as requirements for future referrals. I authorize the use of this signature noted below on all insurance submissions."

I, _____ , have read and understand this form and all my questions were answered:

Authorized Signature: _____Date: _____