

**WELCOME TO ARP FOOT & ANKLE CLINIC, PA
DR. ERIC A. ARP**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following information is provided as a convenience to you to explain our policies and procedures regarding:

INSURANCE: We accept assignment on many insurance benefits. We will be happy to bill your insurance company for you, provided you supply our office with the appropriate up to date information including copies of your insurance card/s and referral if needed by your insurance. Please be aware that we regard your insurance policy as an agreement between you and your insurance company. We are not party to that contract; therefore, in the event that your insurance company has not paid us within 60 days, you may be billed for the balance. Please be aware that some podiatric service provided may be deemed non-covered services and not considered medically necessary under the Medicare program and/or other medical insurance programs.

PRIVATE PAY: Prior to receiving treatment, we may require you to sign a promissory note agreeing to monthly payments. An initial deposit will be required for services rendered at that time.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and office charges that are considered usual and customary for our geographic area.

METHODS OF PAYMENT: We accept cash, check, Visa or MasterCard. There will be a payment expected the day of service. An extended payment plan may be offered with **prior** approval. Balances under \$200.00 are to be paid within 3 months. Balances over \$200.00 are to be paid within 6 months. If your account is turned over to collections for any reason you will be responsible for all collection fees.

BILLING: Any balance remaining after your insurance company has made its determination is considered your responsibility and must be paid within 30 days. **All non-covered services, annual deductibles or co-payments are due and payable upon completion of visit.** Please let us know if you have any questions or concerns. Your signature below reflects that you have read and understand our policies and procedures.

NAME _____ **DATE** _____