This Is Our Office Financial Policy
PLEASE SIGN ON THE BACK

We at Capital District Podiatry PLLC are committed to providing you with the best possible care. If you have Medical Insurance, we are to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Please note there is a 3.5 % CREDIT CARD FEE for using a credit card.

Unless *INSURANCE ARRANGEMENTS* have been approved in advance by our staff, payment for services is due at the time of services are rendered. We accept payment in the form of cash, check or credit card. We will be happy to help you process your insurance claim at each visit.

Effective July 2023, there will be a $75.00 fee for patients who fail to cancel and/or reschedule an appointment within 24 hours of their appointment. Returned checks and balances older than 30 days are subject to an additional collection fee of $35. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Effective July 2023, there will be a $50 charge for any outside paperwork and/or forms that the Doctor needs to complete and sign.

You must realize, however, that:

1. **Insurance is a contract between YOU and your INSURANCE COMPANY. It is YOUR RESPONSIBILITY to know and understand your own insurance policy including you COPAY amount, whether or not your policy requires a REFERRAL and which laboratory and/or facilities your insurance participates with.**

2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R., "U.C.R." ARE DEFINED as USUAL, CUSTOMARY and REASONABLE fees for the region. Thus, our fees are considered Usual, Customary and Reasonable by most companies. This does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of fees and cost of care in this area.

3. Not all services are a covered benefit in All contracts. Some insurance companies arbitrarily refuse to cover certain services. DME or Durable Medical Equipment may also not be covered in all contracts. Our office may contact your insurance company for coverage of benefits and/ or an authorization, however this does not guarantee any coverage or payment. Any opened or used DME can not be returned. Patients are responsible for services and/or DME that are not covered, denied or have coinsurance /copay. Every effort will be made to inform you of your coverage, however some insurance will not divulge any coverage details except if it is covered or not covered. We have no control over this.

4. MEDICARE PATIENTS: We would like you to understand that taking ASSIGMENT means that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% (coinsurance) of what Medicare allows. You are also responsible for services that you co-insurance doesn't cover. If your co-insurance doesn't pay this amount, YOU are responsible for it.

5. SELF PAY PATIENTS: Payment is due at time of service.

Unlike some offices, the FILING OF INSURANCE CLAIMS is a COURTESY that we have always extended to our patients. However, all charges are YOUR responsibility, NOT your Insurance Companies. We will make our BEST EFFORT to collect from them, but if, despite our best efforts, we are NOT SUCCESSFUL, YOU are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact our billing office at 5183481276 promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help.

Your Signature

Please SIGN THE INSURANCE and/or MEDICARE ASSIGMENT BELOW:
I authorize payment of MEDICAL BENEFITS be made on my behalf to Capital District Podiatry Pllc, for any service furnished to me. I authorize the release of any medical information held by Capital District Podiatry Pllc, the health care financing administration and its agents, to process my claims.

Your Signature

Capital District Podiatry, PLLC
Dr. Tejas R. Pandya, D.P.M.
Ph (518) 273-0053 Fax: (518) 271-2052