Financial Responsibility and Policy Sheet
Barth Wolf DPM and Daniel Reznick DPM

Printed Patient Name: ____________________

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following polices.

INSURANCE: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment/deductibles. **This office's policy is to collect this co-payment/deductibles the day of your appointment.**

The co-payment made at the front desk is for the visit only often considered the time you spend with the doctor. If you have any procedures performed during your visit to our office, the procedure may not be covered in the co-payment made at the front desk. In other words, the amount you pay during your visit may not be all you owe. Your final responsibility will be determined after your insurance company has received a bill for all services rendered, processed and paid your claim.

Miscellaneous:

You acknowledge that the insurance card and information provided each visit is the correct and current information. You understand that it is your responsibility to inform our office if a change in your insurance coverage occurs.

In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

If your treatment requires surgery performed at the hospital, we will bill your health plan for all our services provided in the hospital. You understand that these physician fees are separate than surgical assists, hospital anesthesia, and lab or pathology fees.

Uninsured patients: As a private pay patient you will be asked to make payment the day of your appointment. It is very important that you ask about the cost of care or services that your physician is recommending prior to the service being performed.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to the office of Dr Howard Reznick and Associates, doctors Barth Wolf and Daniel Reznick, for medical services rendered to myself and/or my dependents regardless of insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance..

I have requested medical services from the Podiatry office of Dr Howard A. Reznick and Associates, on behalf of myself and/or my dependents. I understand by making this request, I become fully responsible for any and all charges incurred during the course of treatment. In the event of default, I understand that the office of Dr Howard A Reznick and Associates may use an outside collection company.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

I have read and understand the financial policy of this practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I agree that a photocopy of this authorization shall be considered as effective as the original.

______________________________ ____________ ______________________

Signature of patient or Guardian Date Relationship to patient