Financial Responsibility and Policy Sheet
Reznick, Wolf and Associates PC
Chelsea Podiatry

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. However, **This office's policy is to collect this co-payment/deductibles in FULL the day of your appointment. This means: If you only have MEDICARE and NO secondary insurance or Medicaid as your secondary (which we do not take) the percentage which they do not cover will be your responsibility. This is all billable services, including Durable Medical Equipment and Orthotics. This will be collected at the front desk at the time of your visit.**

It is up to YOU to know your deductibles and co-pays. YOU need to know what is a covered benefit.

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. 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 pay your balance IN FULL at the time of service.

Assignment of Benefits: I hereby assign all medical and surgical benefits. 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 Reznick Wolf and Associates, P.C., 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 Reznick, Wolf and Associates, P.C., 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 Reznick, Wolf and Associates, P.C. 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 at the front desk.

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Patients Signature (required)