Massard Foot & Ankle Clinic

Dr. Kevin M. Massard, D.P.M.

Thank you for choosing our office to serve your podiatric needs. We welcome you and hope that you will be satisfied with our services.

Office and Financial Policies

1. **Please give 24 hours' notice of appointment cancellation.**
   If you fail to give notice, we will charge your account a $35 missed appointment fee. For missed **Laser** appointments, a $50 fee applies.

2. **Kindly inform our office staff of any changes in your personal or medical information.**
   Such as, address, phone number, insurance information, medications, allergies and anything else pertain to your history.

3. **Our office requires:**
   a. **Copy of your insurance cards**
   b. **Photo ID** (18 and older)
   c. **Copy of a credit card to keep on file for copays and balances.**

4. **Know your own Insurance Plan Benefits.**
   a. **As a courtesy to you,** our office verifies benefit information prior to your visit whenever possible
   b. Be aware the insurance company states that **"the quote of benefits is not a guarantee of payment."**
   c. **WE cannot be held responsible** for any misinformation we are given by your insurance company.
   d. **It is ultimately your responsibility to know your own benefits and to pay the balances as indicated by your insurance company.**

5. **Insurance Claim Filing and Payment**
   a. **Our office files your insurance claims as a courtesy to you.**
   b. If payments from an insurance company is withheld for **ANY REASON** payment in full will be expected from the insured within 30 days of the first statement and /or 60 days of the service date.
   c. **Assignment is accepted on Medicare Part B Claims.**
      This means that Medicare participants are responsible for:
      - Your $140.00 yearly deductible
      - The balance of the 20% co-insurance after Medicare pays 80% of their allowed amount
      - Any **non-covered/routine foot care** procedures

6. **Account Balances**
   a. **Copayments, previously determined non-covered services or services rendered to a non-insured patient are expected at the time of service.**
   b. We accept all major credit cards (with the exception of AMEX), debit cards, check or cash**. A fee of $35 will be assessed for any returned checks.**
   c. Statements are generally mailed form our office on a monthly basis and payment is expected upon receipt. Your account will be considered PAST DUE after 30 days of the first statement and /or 45 days of the service date and DELINQUENT after 60 days.
   d. **Patients account balances that are 90 days past due from the date of service will automatically be charged if no payment arrangements have been made.** If the card is declined, one courtesy call will be made in an attempt to collect payment. If no payment is received after this final attempt, the account will be forwarded to our collection agency.
   e. **Failure respond to your statement will result in the account being sent to a collection agency or an attorney for collection which will make you responsible for all attorney fees, court and collection fees in association with the unpaid balances and may also damage your personal credit rating. If your account is forwarded to a collection agency, a fee of 25% of your total balance will be added to your bill. Extenuation circumstances should be brought to our attention immediately to avoid collection proceedings.**
   f. Payment plans are available with a valid credit card, if you do not have a credit card postdated checks are accepted to be deposited monthly until bill is paid.

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Signature of Patient OR Legal Guardian (if Patient is a minor) Date