WOLF PODIATRY & ASSOCIATES
800 Biesterfield Road, # 625, Elk Grove Village, IL 60007
(847) 437-7377

PAYMENT POLICY – Please read before signing

Thank you for choosing our practice for your foot and ankle care. We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. We have answered a variety of commonly asked financial policy questions below. If you have other questions not addressed here, please talk to our office staff.

What type of payments is accepted?
We accept payment by cash, personal check, VISA, Mastercard and Discover.

Do you participate in my insurance plan?
We participate with Medicare and a number of insurance plans through Alexian Brother Medical Center and Lake Forest Hospital. Please ask our office staff if we participate with your insurance plan.

Do I need a referral to your office?
We are a specialist office according to your insurance company. If you have a HMO or POS plan, you will need to provide a referral from your primary care physician. If you are unable to provide a referral at the time of service, you can either reschedule your appointment or pay in full for the services provided.

I have two insurance policies. Will you bill my secondary insurance for the services I receive in your office?
Yes. We require copies of both insurance cards BEFORE the service is provided.

Do I need to pay my co-pay at the time of my office visit?
Yes. All co-payments are due at the time of service. If co-payments are not paid at the time of service, we will charge a **$10.00** co-pay billing fee.

What if I cannot keep my appointment?
As a courtesy, we call all patients at least 48 hours before their appointment time. We ask you notify us 24 hours in advance if you are unable to keep your appointment. There is a fee of **$35.00** for missed appointments.

I received medical supplies and/or equipment from your office, is this covered by insurance?
Generally speaking, if a supply can be purchased at Walgreens/Target over the counter (gauze sponges, coban/coflex, povodine, pads, Biofreeze) it is **not** covered by insurance. We try to keep our prices close to those you would pay at Walgreens. If you prefer not to purchase these items from our office, just let us know. Most durable medical equipment (DME) (post operative shoes, inserts, walking casts, ankle straps, etc), are covered under most private insurance plans. However, Medicare will not cover some durable medical equipment through our office.

I am divorced and my ex is responsible to cover the medical costs for our child, will you bill him/her for the services my child receives?
Unfortunately, we cannot get involved in the particulars of divorce situations. The parent who brings the child to our office is financially responsible for all charges.

What is my financial responsibility for podiatric services?
Your financial responsibility depends on a variety of factors as explained in the table below.

OFFICE VISIT AND SERVICES

If you have......	**You are responsible for....**	**Our staff will.......**
Commercial Insurance Also known as indemnity, "regular" insurance or 80% / 20% coverage	Payment of the patient responsibility for all office visit, x-ray, injections and other office services at the time of the office visit.	Contact your insurance company and determine deductibles and coinsurance amounts. We will file a claim as a courtesy.
HMO & POS Plans which we have a contract	Providing our office with the referral from your primary care physician. Payment of all copays and deductible at the time of the office visit. Payment of those services not covered at the time of service.	Contact your insurance company and determine deductibles, co-pays and in office non-covered services. File an insurance claim.
PPO Plans which we have a contract	Payment for all copays and deductible at the time of the office visit. Payment of those services not covered at the time of service.	Contact your insurance company and determine deductibles, co-pays and non-covered services. File an insurance claim.
HMO, POS & PPO Plans Which we ***do not*** have a contract and **Patients without insurance**	Payment in full for the office visits, x-ray, injection and other services at the time of the office visit.	Provide the necessary information and paperwork you require to file the claim yourself.
Medicare	Payment of your annual Medicare deductible and 20% co-insurance as deemed by Medicare. We will bill you after your office visit.	File a claim to Medicare. File a claim to your secondary insurance. Send a bill for the amount Medicare and your 2nd insurance allows.

What happens if I do not pay my co-payment and deductible at the time of service?
We will send you a statement showing the amount you owe after your insurance company has paid their share. Full payment is expected within 30 days from the statement date.

What happens if I do not pay my statement?
We will charge a $10.00 billing fee for all balances over 60 days old. If your bill remains unpaid, we will continue to charge the monthly billing fee. Unless a payment plan is arranged with our office manager, Jackie, all accounts over 120 days old may be forwarded to our collection agency. A collection agency forwarding fee will be assessed at the time of the account transfer. The collection agency transfer fee is as follows: **$25.00** for accounts with a balance less than $75.00; **$50.00** for accounts with a balance less than $200.00; **$75.00** for accounts with a balance less than $350.00 and $**100.00** for accounts more than $350.00.
In addition, you may be responsible for all attorney fees as determined by law.

If you have additional questions we have not addressed here, please contact our office at **(847) 437-7377.**

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WOLF PODIATRY PAYMENT POLICY

I have read, understand, and agree to the above Payment Policy. I have been given a copy of this policy for my future reference. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to Wolf Podiatry & Associates.

I authorize Wolf Podiatry & Associates to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

I authorize Wolf Podiatry & Associates to release personal, financial and medical information to a collection agency, attorney or credit reporting agency in the event I fail to pay my account balance. I understand the fact that I or my children received medical treatment at Wolf Podiatry & Associates may become a matter of public record.

I understand the missed appointment fee(**$35.00**), co-payment billing fee(**$10.00**), monthly billing fee (**$10.00**) and collection agency fees (**$25/$50/$75/$100**) as described in the payment policy.

I understand once I sign this agreement, all terms and conditions will be in full force and effect. Further, I understand and agree to the terms outlined in this financial agreement.

Patient Name: ____
(Please print)

Patient Signature: ____ Date: __________
or authorized guardian

Wolf Podiatry
Authorized Signature: ____ Date: __________

RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the Privacy Notice. For additional information the full Notice of Privacy Practices is located in the waiting room.

Patient Signature:______________________________ Date:____________________
Or authorized guardian

Wolf Podiatry
Authorized Signature:______________________________ Date:____________________

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