PARADISE PODIATRY GROUP
Robert M. Victor, D.P.M.

Treatment of all Foot Disorders and Injuries

PATIENT FINANCIAL POLICY

1. We will bill your primary (and secondary) insurance company as a courtesy to you provided we have all necessary information (including insurance company name and address), or we can provide a receipt for you to send to your insurance company. **If you do not have insurance, full payment is expected today.**

2. We will attempt to verify benefits for some specialized services or referrals. Patients are also encouraged to contact their plans for clarification of benefits prior to services rendered. In the event your health plan determines a service to be "not covered," you will be responsible for the charge.

3. Once the balance has been determined your responsibility, we will send you a statement. If we do not receive payment from you after the second statement, you will be charged a $10 late fee and given a final notice. Your account may then be turned over to a collection agency.

Your signature on this page certifies that you have read, understood and agreed to the policy stated above.

It authorizes the release of any medical information necessary to process this claim for services.

It authorizes payment of medical benefits to **Paradise Podiatry Group** for services described on itemized statements and/or insurance forms.

Signature of Patient/Responsible Party: _____

Name of Patient/Responsible Party: _____ Date: _____

Reviewed and Witnessed by: _____