Michael C. Piccarelli, DPM
Associate, American College of Foot & Ankle Surgeons
272 Slosson Avenue
SI, NY 10314
718-273-0123

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

All new patients and patients that have changed insurance carriers must fill out patient information forms prior to seeing the doctor. We will request to photocopy your insurance card(s) for your file.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25 may then be added to your account.

- **REFERRALS** – If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay that co-pay at each visit. Also, some plans may have a diagnostic or radiology co-pay which should be paid when appropriate.

- **OUT OF NETWORK PLANS** – We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance. Should you receive payment from your insurance carrier, please forward it to the physician's office.

- **SELF PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of the minor child is responsible for payment of services rendered.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

We accept cash, checks, Mastercard, Visa, American Express or Discover Card (There will be a $25 fee for returned checks).

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: ______________________________

Responsible Party Signature: ______________________________ Date: ______________

Print Name: ______________________________