

**Susan Schmitt, M.D., GCFP**  
**FINANCIAL POLICY ACKNOWLEDGEMENT**

We are committed to providing you with the best possible care. If you have insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

- You will need to provide our office with your social security number, a copy of your driver's license or picture ID and health insurance card unless your total charge is paid in full at time of service. Treatment may be postponed if the patient does not furnish the above information.
- For the convenience of our patients, we offer the following methods of payment of fees. Cash, check, money order, Visa and MasterCard.
- Private pay patients are required to pay a minimum of \$75 at time of service for each appointment, or you can receive a 15% discount if paid in full at time of service.
- A \$100 deposit is required for all Motor Vehicle accident patients. Should your PIP expire, exhaust, or claim is denied monthly payments of \$75 are required. Items not covered like natural medications, braces, forms, etc. are patients' responsibility.
- All accounts are due and payable at the time of your visit, unless arrangements have been made with the billing office. This includes all co-pays and deductible. These arrangements must be made BEFORE treatment is rendered.
- Primary insurances will be billed by the clinic as a courtesy. It is the responsibility of the patient to verify that the clinic has their correct insurance information and to inform the clinic if there are any changes with their insurance provider. Remember, an insurance policy is a contract between the patient, the patient's employer, and the insurance carrier. Any questions or disputes about the insurance policy, for example what treatment is covered and by how much the treatment is covered, you will need to resolve with your insurance carrier.
- **Please be aware that many insurance companies assign a co-pay to the office visit portion of your charges only. Manipulation, injections, exercise therapy, massage, diagnostics and lab work are considered separate from the office visit and may be subject to your deductible and co-insurance.**
- Physicians in this facility may prescribe natural medications from this office to you. Worker's Compensation, Motor Vehicle and regular health insurance carriers **DO NOT** cover the cost of these medications as they consider them over the counter medications. It is therefore the patient's responsibility to pay for these items at time of service.
- All braces, splints, heel lifts and arch supports are billed to your insurance carrier. In the event that your insurance policy does not cover these items, you will be responsible for payment in full.
- 24-hour notice is required for canceling appointments with our massage or exercise therapists. **There is a \$60 fee for all appointments for massage and exercise not cancelled within 24 hours.** This amount **will not be billed** to your insurance company. **You will be responsible for paying this amount.**
- In the event that we have to turn your account over to a collection agency any reasonable fees, collection fees and or attorney's fees may be added including but not limited to an interest rate of 9% annum from your original date of delinquency.
- Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your insurance carrier.
- All liability claims must pay a \$100 deposit and make monthly payments of \$75.00, unless special arrangements have been made before your first visit with the billing department or office manager.
- **All forms including FMLA and Disability will be charged a minimum of \$25.00 for the physician to fill out.** This charge will not be billed to the insurance carrier. Patient is responsible for payment at time of service.

**Please sign and return to the receptionist.**

*I acknowledge that I am financially responsible for all charges whether insurance pays or not. I have been advised that if my insurance company does not wish to cooperate in paying the doctor's fees, the doctor will not await payment, but will require me to pay in full or arrange for payments on a monthly basis. A photo static copy of this authorization shall be considered as effective and valid as the original. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to process claims and to secure payment directly from the insurance carrier.*

\_\_\_\_\_  
*Patient's or guardian's signature*

\_\_\_\_\_  
*Date*