Rorick Podiatry PC

Dr. Gregory S. Rorick, DPM
Board Certified
Podiatric Medicine and Surgery

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FINANCIAL POLICY

Rorick Podiatry PC of NY, the physicians and staff are dedicated to providing the best possible care for you. We value the trust and responsibility you place in us to provide you with quality care. We want you to ensure that our financial policies are clearly presented and understood by you. If you have any questions regarding our financial policies, please contact our billing office at 315-736-2080.

1. Insurance: It is your responsibility to know your insurance benefits and confirming our participation with your plan. You must present your insurance card(s) at each visit. We will also have to maintain a copy of your driver's license on file. Failure to provide current and accurate insurance information to us prior to your visit may result in payment in full at time of service or in the event the insurance is denied due to inaccurate information that was provided. t is your responsibility to ensure that we participate with your insurance carrier and whether you require a referral from your PCP or not. Our office cannot always tell you in advance whether or not your charges will be covered by your insurance plan. Each insurance company has multiple plans that can vary with employer group contracts. Since your coverage is a contract between you and your insurance carrier, we expect you to be aware of services that may not be covered under your contract. It will be your responsibility to pay for the bill if the service was already rendered.

2. Appointments: We ask that you appreciate the fact that if you miss or cancel an appointment at the last moment, we will be unable to fill your time slot with another patient who needs an appointment. (You would expect the same consideration when you have an urgent problem and need us to see you.) Therefore, if you need to cancel or re-schedule your appointment **we ask you to give us 24 hours notice or reasonable amount of time with a reasonable excuse**. If you fail to give us such notice, we will charge you a $50.00 (new patient), $25.00 (established patient) no-show fee (which is not covered by insurance). Excessive abuse of the scheduled appointments (no shows, chronic lateness, etc.) may result in discharge from the practice.

3. Co-Pays, Coinsurance and Deductibles: As a part of your contract with your insurance carrier, all co-payments are required at the time of service. In addition, you are responsible for all coinsurance and deductibles. Failure to do so may result in termination of your insurance. For your convenience, we do accept cash, personal checks, money orders, Visa, MasterCard, and Discover. **Payments made with credit cards will be charged a 4% fee to cover our administrative costs (effective November 1, 2019). All returned checks will be charged a $35.00 processing fee.**

4. Collections: Patients who do not make reasonable progress toward resolving outstanding debt to the practice may be turned over to our collection agency. If this occurs you will be responsible for the outstanding balance due to our practice and there will be an additional 35% of the balance charged to your account for collection agency processing. All accounts with a balance over 30 days will be assessed a 1% rate charge per month on the unpaid monthly patient balance. In addition, you may be responsible for any attorney fees in addition to the balance.

5. Forms and Documents: Occasionally, we are asked either by patients or insurance companies to complete various forms which are not related to any claims for benefits for our services. If you ask us to fill out claims for disability benefits or insurance pre-certification forms for certain drugs or prescriptions, or other variations, our charges for each form will be a $10.00 fee. Payment must be made prior to completion of the forms. Requests for copies of your medical records will be copied for you at a charge of $.75 per page. This will help offset the administrative expenses incurred by our office.

It is important that you understand our Financial Policy. Our fees are representative of the usual and customary charges for our area. Please feel free to contact us with any questions.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature_____Date_____