

Thank you for choosing Ronald J. Belczyk, DPM, Inc as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that you will be financially responsible for charges that are not covered by your insurance. If you have any questions regarding your financial account with our office, please contact us by phone at 747-263-9696, or email us at billing.dept.ronaldbelczykdp@gmail.com.

PATIENT FINANCIAL POLICY

- We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered.
- If you do not provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We accept cash, check, or credit card (Visa, MasterCard, Discover, or Amex).
- Please notify us immediately if there are any changes to your insurance plan or your coverage.
- Co-payments and Deductibles are an agreement between you and your insurance plan and are your responsibility.
- Co-payments are due at the time of service and charges to cover your deductible may be requested to be paid toward if it has not been satisfied.
- Medical records or copies of records can be provided at your request; please allow up to 5 (five) business days for records to be compiled.

SELF-PAY

Full payment at the time of service is required unless prior arrangements have been made.

MEDICARE

We accept Medicare assignment. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.

HMO/PPO

We are providers for many insurance plans, but not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you must have a current referral at the time of your visit in order to be seen, and for the visit to be covered under your plan. Without a proper referral, you may be responsible for charges incurred. If you are a PPO member, you are responsible for co-payments, deductible, and co-insurance. Please confirm with your insurance that we are providers covered under your plan.

WORKERS' COMPENSATION

In the case of workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

HOSPITAL & SURGERY CENTER CHARGES

In the event that you undergo surgery in a hospital or outpatient surgery center, separate charges will be made by the facility.

UCR (USUAL & CUSTOMARY RATES)

We are committed to provide the best treatments possible for our patients. Our fees for services rendered are usual and customary for our geographic area. If we do not have a contract with your insurance company, you are responsible for your payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

PATIENT FINANCIAL POLICY AGREEMENT

I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check or credit card. Past due balances may be subject to additional fees. I understand that if the office agrees to bill insurance as courtesy, I must submit information as needed in a timely manner, to ensure that payment for services is rendered. I understand that I am ultimately responsible for payment of all services.

X _____
Patient or Guardian's Signature

Patient or Guardian Name Printed

Date