

UNIVERSITY PODIATRY GROUP Billing Policy

Explanation of new changes to billing policy:

Due to changes in healthcare that have decreased physician reimbursements and increased the clerical and administrative work required to secure payment for medical services rendered, the University Podiatry Group has decided to change its billing policy for the collection of co-payments and payment balances, *effective January 1st, 2009*.

The University Podiatry Group will no longer send invoices to patients for balances or co-payments. We will require a credit card number to be kept on file. When the Explanation of Benefits (EOB) paperwork is received from your insurance company, which indicates the amount that the patient is responsible for (i.e. co-payments, deductibles, etc.), your credit card will be directly charged for those fees. ***You will ONLY be charged for amounts that your insurance company has determined to be the patient's responsibility.***

Another option is for the patient to pay for the services rendered at the time of the visit by cash, check or credit card. If and when the insurance company makes its payment to us, a reimbursement will be forwarded to you in a prompt manner.

As a courtesy to our patients, we will continue to bill insurance companies for services provided by our doctors.

Thank you for your understanding and compliance with our office policies.

Sincerely,

The doctors of the University Podiatry Group

AUTHORIZATION TO CHARGE CREDIT CARD

Patient name: _____ UPG MR# _____

- I have read the above policy and authorize the University Podiatry Group to keep my signature on file and to charge my credit card for the balance of charges to my account (deductibles, co-payments, and non-covered services) *NOT* paid by my insurance.

Credit card type: VISA MC AMEX 3 digit security code: _____

Credit Card #: _____ Expiration date: _____

Printed name on card: _____

Cardholder's signature: _____ Date: _____

- I have read the above policy and choose to pay for all services rendered at the time of my visit with the doctor.

Patient signature: _____ Date: _____