BERKS FOOT & ANKLE SURGICAL ASSOCIATES, INC.

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FINANCIAL POLICY AGREEMENT

This is an agreement between Berks Foot & Ankle Surgical Associates, Inc as creditor and the patient/debtor named on this form. In this agreement the words you and yours mean the patient/debtor. The word account means the account that has been established in your name to which charges are made and payments credited. The words we and our will hereafter refer to Berks Foot & Ankle Surgical Associates, Inc. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements: In the event there is a balance remaining on your account, you will receive a monthly statement. If we need to bill you more than once for a charge, a service charge will be automatically included by the computer. This will not be waived.

Payments: Your balance is due and payable when the statement is issued, unless other arrangements are made with the billing department, and past due if not paid by the 10th of the next month. This will generate a service charge. <u>If there is a PAST DUE balance, there will be no appointment scheduled until it is resolved.</u>

Insurances: If your insurance is a plan in which we are participants, we will bill your insurance company at the time of your visit and adhere to the conditions of our contract with them. If it is <u>not</u> an insurance in which we participate, please speak to the billing person or the office manager to make other arrangements. We will only bill two insurance companies. After receiving any and all payments, we will bill you the balance that you are responsible for according to the insurances. If your insurance plan requires a referral from your Primary Care, it is the <u>PATIENT'S RESPONSIBILITY TO OBTAIN THE REFERRAL.</u>

Collection Agency Fees: If your account becomes delinquent, we will take the necessary steps to collect this debt, which includes referring your account to our collection agency (a $50 charge). You agree to pay <u>all</u> of the collection costs which are incurred. <u>NO APPOINTMENTS WILL BE GIVEN IF YOU ARE IN COLLECTIONS</u>. In the event we have to refer the collection of a balance due to a lawyer, you agree to pay all incurred lawyers' fees plus all court costs. In case of suit, you agree, the venues are in Berks County, Pennsylvania. You understand if this account is submitted to an attorney or collection agency, and litigation in court ensues, knowledge of your being a patient at our office may become public record.

Missed Appointment Fees: If appointments have been missed, it is at the doctor's discretion to charge you for a missed appointment. The charge for a missed appointment is $50 and this is not a charge that can be submitted to the insurance company.

Divorce: In the case of divorce or separation, the party responsible for the account prior to divorce or separation remains responsible. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: In the event you need to transfer your records, a request must be made in writing. The following charges apply:

- Copy of x-ray images to disc - $15 per disc
- Copy of your chart - charge per the established fee schedule

Worker's Compensation/Personal Injury: If you are being treated under worker's compensation, we require all information in order to submit your claim to the proper insurance company. If your claim is denied, we will submit the claim to your personal insurance for your convenience.

If you are being treated for a personal injury, we require verification from your lawyer. In addition to the verification, you will allow us to bill your personal health insurance. In the absence of insurance, or if some reason this is denied by your insurance company, you are responsible for payment in full at the time of service, unless other arrangements have been made with the billing department. This all goes with the understanding that this is primarily your responsibility.

There will be a $10- $50.00 fee (amount depends upon number of submissions/complexity required) charged for completion of paperwork, due upon completion.

Effective Date: Once you have signed this agreement, you agree to all the term and conditions contained herein and the agreement will be force and effect. If this is not signed, we reserve the right to ask you to pay all charges in full at the time of service. We also reserve the right not to accept you as a patient in the practice.

Patient's Name: ____
(PRINT)

Responsible Party (if not the patient): ____

Signature: ____ Date: ____________________

Witness: ____ Date: ____________________