FINANICAL POLICY FOR ERIC J LULLOVE, DPM PA **effective 12-1-2009**

Thank you for choosing our office to provide you with podiatric medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

COPAYS: *All* Co-Pays are due at time of service and may not be waived, billed or paid later.

SELF-PAY: Payment is to be made in full at time of service if you do not have health insurance.

MEDICARE: This office is a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. You are responsible for co-payment or deductible amounts as stated by Medicare and your secondary insurance company.

SECONDARY INSURANCE: You medical claim will be forwarded to your secondary insurer after Medicare determines payment as explained on the EOBs.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (Co-payments, co-insurances, deductible) after payment and/or explanation of benefits is received from your insurance company. After the third and last notice, your account will be forwarded to collections. Payment arrangements may be made on a case-by-case basis. This office accepts major credit cards, VISA, MasterCard, American Express. Checks that are returned are subject to a $50.00 returned check fee for insufficient funds.

COLLECTIONS: All delinquent accounts (greater than 120 days) will be sent to a collection agency. All delinquent accounts will be charged the legal rate not to exceed the allowable rate under Florida law for that particular calendar year. Should it be necessary to assign your account to a collection agency or an attorney, you will be responsible for all collection agency fees, legal fees, court costs and other costs associated with collection of debt.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your PCP prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at time of visit. Referrals presented within 72 hours of the office visit will be credited to your account in full. As a courtesy, we will still see you without a referral but you will be responsible for all costs incurred for that visit without the referral.

I have read the above policy regarding my financial responsibility to ***Eric J Lullove DPM PA*** for providing medical services to me or the below named patient. I agree to pay ***Eric J Lullove DPM PA*** any monies due after insurance payment has been made by my insurance carrier and contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if there is no health insurance coverage existence.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to ***Eric J Lullove DPM PA*** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurances and/or non-covered services. I hereby authorize ***Eric J Lullove DPM PA*** to release all information necessary to secure payment of benefits. I authorize the RELEASE OF ALL MEDICAL INFORMATION to my insurance carrier or requesting physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform ***Eric J Lullove DPM PA*** of any and all changes to my health insurance information and/or status of coverage.

PRINT Patient Name: _____ SIGNATURE:_____

FINANCIALLY REPSONSIBLE PARTY:

PRINT Name: _____ SIGNATURE: _____

Relationship to Patient: _____