2. FINANCIAL POLICY AND AUTHORIZATION FOR TREATMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is DUE AT THE TIME OF SERVICE unless payment arrangements have been approved by our staff in advance. We accept cash, checks, Visa, Mastercard, and Discover. We will be happy to help you process your insurance claim for your insurance benefits (i.e., the insurance company will pay us directly **IF** the assignment is signed by you).

There is a charge for returned checks, and balances older than 30 days may be subject to an additional billing fee of $25. Charges may be made for appointments cancelled without notice. We will gladly discuss your proposed treatment and answer any questions relating to you insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies to companies who pay a percentage (such as 50% or 80%) of UCR (Usual, Customary, and Reasonable).
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain benefits they will not cover.

We must emphasize that as a health care provider, our relationship is with you, NOT YOUR INSURANCE COMPANY. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date foot services is rendered. We realize that temporary financial problems may affect the timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE let us know. We are here to help you.

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I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize payment to DR. DAVID A. LIEB, D.P.M. for any professional services rendered, including Major Medical. I also understand that I will be responsible for attorney's fees, court costs, and collection fees (33%-50% of outstanding balance) in the event my account is turned over for collection. I also hereby give permission to DR. DAVID A. LIEB to administer and perform treatment procedures as may be necessary in the diagnosis of my foot problems.

I certify that I have read and understand the above policy, and I hereby give my consent for treatment.

Signature:_____Date:____/____/_____