Foot & Heel Pain Institute of Michigan

Tara Long Scott, DPM Asmaa Abada, DPM

Office Policy

Patients are expected to pay for their office visit at the time of service, unless we have verified that your health insurance covers office visits and will reimburse us directly. All co-payments must be made at the time of service.

It is your responsibility to understand your insurance coverage. There are numerous types of insurance coverages available. If you are enrolled in a health maintenance organization (HMO) or some other type of managed care plan, you are required to have a written referral for each and every visit. We will not see you without your referral unless you are willing to pay for the visit. It is your responsibility to know your unique insurance requirements and arrange for your authorizations or referrals when necessary. Since we are not party to your agreement with your insurance carrier, it is not our policy to establish why they have not paid, or why they paid less than anticipated. You will need to contact your carrier directly for any questions regarding their reimbursement policies. You are personally responsible for any unpaid balances.

Many insurance policies require that you meet a specific annual deductible. Payment of your deductible is your responsibility. We do not absorb your deductible.

Unpaid balances are due upon receipt of your statement, unless payment arrangements have been made.

If you have been involved in a car accident or work related incident, it is your responsibility to notify this office and provide authorization and billing information from your auto or worker's compensation carrier. We must have this information prior to your being seen.

Termination of care will result if your account becomes three months delinquent. We will bill your insurance company for most services; however, you are directly responsible for your account should your insurance company fail to pay us. Accounts not receiving any payments for over 6 months are subject to be sent to collection or settled in small claims court.

Failure to call and reschedule or cancel an appointment will result in a $25.00 charge to the patient.

I have read the above office policy and agree to their terms.

Patient Signature: _____ Date: _____

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