PAYMENT POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care at affordable costs. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. We ask you to read the policy carefully and sign prior to any treatment.

INSURANCE: We participate with most insurance plans. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and coverage is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Please understand it is your responsibility to inform the doctor's office if there is a change in your health insurance information and/or contact information. If you are not insured by a plan we participate with, payment in full is expected at the time service is rendered, unless arranged otherwise.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS, COINSURANCES AND DEDUCTIBLES: All co-payments, co-insurances and deductibles must be paid in full at the time service is rendered, unless arranged otherwise. For scheduled surgeries and procedures, a deposit will be required, along with a credit card at the time of booking to guarantee payment for any patient co-pays, co-insurances and deductibles that may be due unless a cash or check deposit, or other arrangement is made.

ACCOUNT BALANCES: Patients with account balances are required to pay their account to a zero balance prior to receiving further services by Dr. Geller. Any balances will be collected at the time of the next scheduled visit.

SELF PAY: Payment in full is due at the time service is rendered if you do not have health insurance, unless arranged otherwise.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by insurance. We are happy to check benefit coverage, however, this is still not a guarantee of payment by your insurance carrier. You are responsible for payment of these services in the event they are not covered by your insurance.

APPOINTMENT CANCELLATIONS: If an appointment is not cancelled at least 24 hours in advance of your scheduled appointment time, you will be charged a $50.00 cancellation fee. This fee is not covered by your insurance and must be paid in advance of your next scheduled visit.

SURGERY CANCELLATIONS: Due to the large block of time needed for surgery, if a surgical procedure is not cancelled at least 7 days in advance of your scheduled procedure you will be charged a $150.00 cancellation fee. This fee will be waived if Dr. Geller cancels the procedure due to a patient not being medically cleared for surgery. This fee is not covered by your insurance and must be paid in advance of your next scheduled surgical procedure.

NO-SHOW FEE: Patients who do not show up for their appointment or procedure without a call to cancel in the time periods set forth above, will be considered as NO SHOW, and will be subject to the above appointment and surgery cancellation fees. This fee is not covered by your insurance and must be paid in advance of your next scheduled visit.

ORTHOTIC CASTING: The cost of one pair of custom orthotics is $500. Should you decide during your visit to be casted for orthotics, it is our policy that a $150 deposit is due upon casting. This is a refundable deposit with payment in full from your insurance carrier. Insurance reimbursements typically take at least 30 days once a claim has been submitted. We cannot dispense orthotics until full payment has been received. You have a choice to wait until your insurance company processes the claim to receive your orthotics or to pay the full amount of $500 upon casting to receive

your orthotics within two weeks. Your deposit will be refunded when payment is received from your insurance carrier, less any copays, co-insurances, and/or deductibles owed to the office for services rendered. Should you decide you no longer want the custom orthotics post casting your $150 deposit will be forfeited. You should be aware there is a possibility that your orthotics ***may not*** be covered by your insurance carrier, and you will be responsible for the full amount. We are happy to check coverage of this benefit, however, this is still not a guarantee of payment by your insurance carrier, even after verification may be received.

SHOCKWAVE THERAPY TREATMENT: The cost of each Shockwave Therapy Treatment is $150. Should you decide during your visit to undergo a Shockwave Therapy Treatment payment of $150 will be due at the time service is rendered. You should be aware that Shockwave Therapy Treatment ***is not*** typically covered by your insurance carrier.

PLATELET RICH PLASMA AND AMNIOX INJECTIONS: Platelet Rich Plasma Injection (or PRP Injections) and Amniox Injections are not covered by your insurance. Should you decide during your visit to undergo a PRP or Amniox Injection payment will be due at the time service is rendered. We can submit the claim to your insurance carrier and your deposit will be refunded when payment is received from your insurance carrier, less any copays, co-insurance, and/or deductibles owed. You should be aware that PRP and Amniox Injections are ***not typically*** covered by your insurance carrier, and you will be responsible for the full amount. We are happy to check coverage of this benefit, however, this is still not a guarantee of payment by your insurance carrier, even after verification may be received.

LASER NAIL THERAPY. Laser Nail Therapy Treatment is not covered by your insurance. Should you decide during your visit to undergo a Laser Nail Therapy Treatment payment in full will be due at the time service is rendered. You should be aware that Laser Nail Therapy Treatment ***is not*** covered by your insurance carrier.

INDIGENCE DISCOUNTS: We may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigence Policy in accordance with applicable federal and state laws.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan, which may mandate that when you visit a specialist such as us, you have a referral from your primary care physician prior to seeking specialty care. Therefore, if a referral is required, you are financially responsible for the services received, unless your referral, naming Dr. Daniel Geller, is presented at the time of the visit.

CLAIM SUBMISSION: As a courtesy service to you, we will submit your insurance claims for in-network services rendered in our office and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or Explanation of Benefits (BOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to a Collections Agency. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, Check, or VISA/Mastercard/Discover/American Express. An additional $50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance, otherwise you will be billed and responsible for the balance.

PATIENT COOPERATION: If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

Daniel Geller Podiatry, PC
11600 Wilshire Blvd. #205
Los Angeles, CA 90025
(310) 395-5025

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

ASSIGNMENT OF BENEFITS/DESIGNATION OF AUTHORIZED REPRESENTATIVE:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

We are committed to serving you with highest quality care possible at affordable cost. If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation.

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I have read the Financial Policy for Daniel Geller Podiatry, PC, and understand and agree to its terms.

PRINT Patient's Name: _____ Signature: _____

PRINT Financially Responsible Party's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

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