Katheryne W. Glantz, LTD **2345 E. Prater Way # 315, Sparks, NV 89434**
DBA High Desert Foot & Ankle Clinic **775-331-3668**

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have questions about our fees, Financial Policy, or your responsibility.

- All deductibles and co-pays are due at the time of service.
- We accept Cash, Check, Money Order, Visa, MasterCard, American Express and Discover for your convenience.
- The adult accompanying a minor, and his/her parents or guardians are responsible for co-pay and/or deductibles at the time of service, and must accompany the patient to each visit unless prior arrangements have been made.
- If you have insurance, we will help you receive maximum benefits. Please be aware your insurance company may not cover all treatments. You will be responsible for non-covered service related to podiatry. The insurance handbook you receive from your employer has the most accurate information regarding your insurance coverage.
- Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved with disputes between you and your insurance company regarding deductibles, copayments, covered charges, "usual and customary" charges, and etc. other than to provide factual information as necessary. The patient is still responsible for the bill if the insurance carrier does not pay within 60 days. **Eligibility and/or authorization are not guarantee of payment from your insurance company.**
- We do not bill secondary insurances for balances under $100.00, excluding Medicare patients whose insurance automatically crosses over.
- You are responsible for the payment of your account at the time of service.
- Unless your appointment is canceled at least 24 hours in advance, you will be billed $50.00 per missed appointment. Please help us serve you better by keeping your scheduled appointment. **PLEASE INITIAL ____**
- It is the patient's responsibility to bring a referral from the primary care provider for your next visit with Dr. Glantz. Otherwise payment will be due from you at the time of service.
- We will be happy to provide copies of the doctor's treatment notes to aid you in the completion of your disability insurance carrier, at no charge to you. However, if your disability insurance carrier requires the doctor to complete specific form(s) for them, there will be a $25.00 charge for each page/form. This fee must be paid by you before form(s) will be completed.
- For Medicare patients, please be aware that many podiatry services are not covered.
- Returned checks will incur a minimum $50.00 fee and up to three times the amount of the check as Nevada law allows.
    1. I understand that if I do not pay my account with Dr. Glantz in full that my account may be assigned to a collection agency for collection.
    2. I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission or fee that may be as much as 50% of the amount I owe to Dr. Glantz. I agree that if my account is assigned to a collection agency, that Dr. Glantz may add the amount of the collection agency's commission or fee to the amount that I owe Dr. Glantz, and I agree to pay the additional amount.
    3. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for medical services. I understand, for example, that if my unpaid balance that I owe to Dr. Glantz is $1000.00, that Dr. Glantz may add up to $500.00 to my account, and I agree to pay the sum of $1500.00 in such event.
    4. I understand and agree that in the event legal action is commenced to enforce my obligation hereunder, that I will pay court cost and reasonable attorney fees.

If you have any questions regarding this policy, please check with our staff immediately.

_____ _____

Signature of Patient or Responsible Party **Date**

_____ _____

Signature of Witness **Date**