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## FINANCIAL POLICY

Thank you for choosing Waukesha Foot Specialists as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and ask any questions that you may have. Once you accept the policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. 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 is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. **If you have an unmet deductible, we pre-collect 60% of the charges incurred that your insurance will apply towards your deductible.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of Insurance.** All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.
5. **Claims submission.** We will bill your insurance company as a courtesy to you. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If you have a secondary insurance company, we will bill them one time. If your secondary insurance does not pay the balance due within 45 days, the balance will be billed to you and due that time. Your insurance benefit is a contract between you and your insurance company.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Nonpayment.** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If balances are not paid within 30 days from the statement date, a \$10.00 rebilling fee will be added to each additional statement sent for the unpaid balance. If your account is over 60 days past due, you will receive a letter requesting immediate payment. Partial payments will not be accepted unless otherwise approved by our Billing Department. A consistent attempt will be made to collect outstanding account balances. Past due accounts, more than 90 days, will be turned over to our collection agency and a

35% fee of the balance will be added to cover collection costs. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments.** Our policy is to charge \$30.00 for missed appointments not cancelled within 24 hours or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us out to serve you better by keeping your regularly scheduled appointment.
9. **Forms and Documents.** It is our policy to charge \$10.00 for completion of all forms, such disability applications, etc.
10. **Supplies/Products.** Complete payment for all podiatry soft goods, medical products and supplies are due at the time they are dispensed.
11. **Fees.** Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read the above policy, agree to abide by its guidelines, and I understand my financial responsibility to Waukesha Foot Specialists for medical services provided. I agree to pay Waukesha Foot Specialists any balance due/or unpaid by my insurance carrier for myself or the below named patient.

Print Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Financially Responsible Party:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_