COREY W. WESNER, DPM SC

Agreement Policies

1. I understand that I am financially responsible for charges not covered by my insurance plan(s) and charges in excess of benefits paid under such plan. I will also be responsible for any services that my insurance company should decide are "non-covered" benefits.
2. Missed appointments. When you reserve an appointment time, it is not available to other patients. We therefore, require 24 hour notice of cancelled appointments. Failure to notify us of your intent to cancel within 24 hours is $25.00 and is non-billable to your insurance carrier. You will be responsible for cancellation fee charges.
3. Payment for services provided by Corey Wesner, DPM, SC is the sole responsibility of the patient or the patient's parent or guardian. Health insurance coverage does not relieve you of your financial responsibility for services rendered.
4. If your insurance company does not pay in full within 60 days from the date of service, you remain responsible for any amounts owed and will be expected to make payment in full at that time. You will be refunded when your insurance company pays.
5. You will still remain responsible if your insurance company requires prior authorization and prior authorization was not received.
6. **As a service to you** we may call your insurance carrier to verify benefits. Please be advised that verification **does not** guarantee payment by your insurance carrier.
7. I understand that it is my responsibility to help get my insurance company to pay. I will call them to prompt them to pay if necessary and I will return all questionnaires and additional information they send me in a timely manner.
8. The minimum monthly payment is **$50.00** per month or **10%** of your bill, which ever is greater.
9. If referred to this office by another health care provider, we have the permission to contact that provider for additional information.
10. I understand that Corey Wesner, DPM, SC **does not** follow divorce decrees, separation agreements or paternity arrangements. The parent/guardian will be responsible for payment of the bill and will be billed accordingly.
11. I understand that I may be charged 1.5% interest along with a $3.00 surcharge fee for each statement printed after 60 days.
12. I understand that if my account is placed with a collection agency, my account will be charged 33% of the amount listed not to exceed $150.00.
13. There is a $15.00 fee **per form** for our office to fill out and complete required insurance forms (i.e. Short-Term Disability, FMLA, deferred credit/loan forms, etc.).

Insurance Assignment and Release

I authorize Corey W. Wesner, DPM, SC to bill my insurance company, exchange information (if requested) and to receive payment for services provided to me. I authorize release of any medical or billing information necessary to process claims incurred by Corey W. Wesner, DPM, SC and the use of my signature on all insurance submissions. In the case that my insurance carrier will not cover services or charges, I agree to pay for services provided to me. I also authorize billing statements to be sent to the person I designate as my responsible party/guarantor including, but not limited to my spouse.

I authorize direct payment to Corey W. Wesner, DPM, SC of all medical insurance benefits including major medical payments otherwise payable to me.

I agree to and understand all of policies of Corey W. Wesner, DPM, SC.

Patient/Responsible Party's Signature_____Date_____