Karen Ackerman, D.P.M., P.A.
2300 N. 14th Ave., Ste. 100A
Dodge City, KS 67801

Mission Statement:

"Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of that treatment. The following statement is our Financial Policy which we require that you read and sign prior to any treatment."

We will gladly bill your insurance for you; however, it is important to remember that your insurance is a contract between you and your insurance company. You as the patient are responsible for your bill. Therefore we require that your visit be paid at the time of service. If we are providers for your insurance, payment of **20%** is expected at the time of service. All insurance **co-payments** are also expected at the time of service as well as any payment that would be applied to a **deductible**. Patients that have both a primary and secondary insurance will not be billed until both insurance claims have been turned in, processed and paid to our office.

I authorize the release of medical information necessary to process claims/medical reports. I authorize payment of medical benefits to the physician or supplier named on the claim form.

If your insurance is one that requires a referral, it is your responsibility to have it when you come into our office. If you do not have your referral you may be responsible for the payment of services at that visit.

Workman's Comp claims require a letter from your employer stating it is a work injury and where we should send the billing. Without that letter we will ask you to pay for the visit and give you a receipt to take back to your employer. Personal injuries are handled much the same only requiring you to have information and a contact person from the insurance company handling the claim.

On orthotic devices we do require a deposit of ½ down at the time of casting, with remaining balance due at time of pickup.

I acknowledge that I was provided a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

We will accept cash, check, or credit card for your payment.

Thank you for trusting us with your care. If you have any questions regarding this policy please feel free to talk with the receptionist and she will be glad to help you.

"I have read, understand and agree to the provisions of the Financial Policy and the Summary of Notice of Privacy Practices."

Signed, _____

(Signature of Patient or Person Financially Responsible for the Bill.)