Timothy C. Runyon DPM PA
1401 16th Street North
St. Petersburg FL
33704 4123

FINANCIAL POLICY

Thank you for choosing **Timothy C. Runyon DPM PA**. Please take the time to read through and sign our financial policy statement. Our practice is built on long term relationships with our patients and those relationships are based on communication and understanding.

Purpose: This is an agreement between **Timothy C. Runyon DPM PA**; the named patient and responsible party on this form. We appreciate you for selecting us as your Podiatrist. We want to be sure you fully understand your financial obligations for the services we will be providing. By signing this agreement, you are agreeing to pay for all services rendered.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance as well as any new charges to the account.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collections agency; if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. Some insurance companies require you to stay within a specific network of podiatrists in order for them to pay for the services rendered or for the full benefit available to you. It is your responsibility to check with your insurance company to verify that your services will be covered here at **Timothy C. Runyon DPM PA**. Although we can estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

PPO's & HMO's: You will be responsible for any copays, deductibles, co-insurances and non- covered services.

****It is the patient's responsibility to verify that any required authorizations/referrals are in place prior to visit****

Minors: In case of minors, any required payment is expected at the time of service. Required payment is the responsibility of the person bringing the child in for treatment. In no case shall a parent be billed unless prior arrangements have been made directly with that parent.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or pay a portion of the treatment costs it is the authorizing parent's responsibility to collect from the other parent.

Past due accounts: If your account becomes past due we will take necessary steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all the collection costs. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which incur plus court costs. In case of suit you agree the venue shall be in Pinellas County Florida.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Effective date: Once you have signed this agreement you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name Printed _____

Responsible Party (If not the patient) _____

Signature: _____ Date: _____