Office, Insurance, and Financial Policies

Here at the Office of Dr. Brent S. Wood, DPM, we believe that part of good healthcare is to establish and communicate our office policies to our patients. We provide the best possible care for you and we want you to completely understand these policies. We ask that you initial in the provided spaces at the front of each section and then sign the bottom to indicate that you have read and understand the following policies.

Payment:

____ Payment is required at the time of your visit. You are financially responsible for all charges and services rendered on your behalf or on behalf of your dependent, whether they are covered by any of your insurance carrier(s) or not. This includes any co-payments, co-insurance payments, or charges not covered by your insurance company. Per insurance guidelines, our office will ask for your Social Security Number, Insurance Card, and an ID or Driver's License. You are welcome to request an estimated quote for charges prior to your visit.
**Please be advised that any labs performed will be billed separately*.

Insurance:

____ To best serve our patients, we are a participating provider with many different insurance plans. All services will be filed to the insurance companies with which we participate. You may check with our office to determine if we accept your insurance. Please remember that an insurance policy is a contract between the patient and the insurance company, thus **the patient is ultimately responsible for any amount not covered by the insurance policy**. Due to the ever-increasing number of insurance products, please be sure to check your benefits and know your coverage. If your insurance plan determines a service is not covered or if they incorrectly quote coverage for services, you will be responsible for the complete amount charged for those services.

___ It is your responsibility to give the most current and accurate insurance information to our office. It is your responsibility to notify our office of any changes to your insurance carrier(s). Any late filing penalties accrued due to incorrect insurance information will be billed to the patient. Our office is not responsible for denied claims due to incorrect insurance.

___If your insurance requires a referral from your primary care physician or a pre-approval for a service, then you are responsible for obtaining that referral or pre-approval. *If your insurance rejects payment for lack of a referral or pre-approval**, you will be responsible** for the cost of the service rendered.*

Medicare (if applicable):

___ All Medicare patients are responsible for your yearly deductible, co-insurance (if any), and any services that Medicare will not cover. It is your responsibility to give the most accurate and current insurance information for your Medicare or any secondary insurances. By initialing and signing this form you agree to allow this office to release any necessary medical and/or personal information in order to bill Medicare or any secondary insurances.

Late Arrival/Cancellation/Missed Appointment (No Show):

____ Our goal is to provide quality individualized medical care in a timely manner. No-shows, late arrivals, and cancellations inconvenience other patients needing access to medical care. If it is necessary that you cancel your scheduled appointment, we require 24-hour notice**. Cancellations *under 24 hours* will result in a "Missed Appointment Fee" of $35.00. Missed or "no show" appointments (*late for more than 15 minutes after the scheduled appointment time*) will be charged the "Missed Appointment Fee."** Please call the office if you need to reschedule your appointment to avoid the "Missed Appointment Fee." Please note that insurance will not pay your "Missed Appointment Fee."

Workers Compensation:

____ Dr. Wood is not a participating provider for Workers Compensation for the state of Texas. If your visit is Workers Comp related, you will need to provide **upfront payment in full for all treatment costs**. You will then need to file a claim with Workers Comp to receive reimbursement.

Consent to Treatment:

____ I consent to the performance of those diagnostic procedures, examinations, and rendering treatment by the medical providers and staff as deemed necessary in the provider's judgement.

By signing, I authorize the release of medical information necessary to process an insurance claim. I authorize payment of medical benefits to Dr. Brent S. Wood, D.P.M. PLLC.

I have read and understand the office policies stated above and agree to accept responsibility for this account. I promise to pay any amount owed on this account. I also understand that I am responsible for any associated fees in collecting on my account balance.

Patient/Guardian Signature: _____

Please Print Name: _____ Date Signed: ____/____/____