Family Foot Doctor
Dr. G. A. Lassus, DPM, MBA
Dr. Krupa Trivedi, DPM
713-784-3668
www.FamilyFootDoctorHouston.com

Office and Financial Policies

Thank you for reviewing the following office and financial policies. We commit to put forward our best efforts to provide you with the most up to date, skilled, and compassionate health care possible. We also agree to:

Provide you and/or your insurance company with a timely and accurate statement of all charges for services rendered.

Explain fully all charges for services rendered and acceptable payment methods.

Secure all pre-authorizations and/or referrals that your health insurance plan requires us to obtain for your ongoing care or treatment.

In return we respectfully ask you to agree to the following:

If you are more than 15 minutes late for a medical appointment, you may be asked to reschedule or to see a different provider.

It is your responsibility to inform us of any changes to your account, such as phone number, insurance, or address changes. If you do not provide us with the correct information and we are unable to receive payment as a result, you will be responsible for the balance.

As a courtesy to you, we will file your insurance claim for you. If your insurance is inactive or does not cover the services provided, you will be responsible for payment. Any balances older than 90 days, which have not been paid by your insurance company, may be billed to you. Any balances remaining after your insurance has paid will be due on receipt of a statement from our office. If your payment is not received within 60 days your account may be referred to a collections agency.

If your insurance doesn't pay under the pre-existing clause then all services will be the patient's financial responsibility.

It is your responsibility to confirm with your insurance if we are in or out of your network, and if the service you request is covered by your insurance.

All co-pays, co-insurance and deductibles must be paid at the time of service.

Any accounts with outstanding balances must be paid prior to any additional services being rendered.

A $25.00 charge will be charged for any returned checks. Checks will be processed electronically.

For your personal use there is a $6.50 charge for your medical records, unless requested by another physician.

If you require short term disability, FMLA or other forms to be filled out by us, these forms will be completed for a fee of $10.00 per form.

As a convenience to our patients, we provide a blood draw station in our office. Charges for most lab tests, including biopsies, are not included in the charges from our office and are billed separately by labs. These charges are NOT included in your regular statements from Family Foot Doctor. It is your responsibility to understand your insurance benefits for lab work.

For all services rendered to minor patients, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

We make every attempt to code and file claims accurately according to the services rendered and your healthcare provider's documentation in your medical record. We are required to code and bill for the type of visit that is performed, not the type of visit that is scheduled. Laws regarding insurance fraud and abuse prohibit us from changing your procedure and/or diagnosis code in order to get the claim paid.

Our office prefers to use email to notify patients of lab results, reminders and other important office information. Please allow 2 weeks to receive notification of your lab or test results. I understand that this office cannot be responsible for information loss or delays that are due to technical factors beyond this office's control.

Please clearly print your preferred email address below if you consent to using email for these preferred communications:

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I have read and understand the above office and financial policies and agree to be bound by these terms. I also understand and agree that Family Foot Doctor may amend such terms from time to time. I have received/read a copy of the HIPAA statement.

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Print Name Signature Date

Thank you. We look forward to having you as our patient.