Mindy E. Lam, DPM 870 Route 146, Clifton Park, NY 12065 (P) 518-371-7133 (F) 518-371-7135

Financial Policy: Agreement for Payment

PLEASE READ AND INITIAL EACH LINE BELOW ACKNOWLEDING YOU HAVE READ ALL POLICIES.

_____**No Show:** Foot Care of Clifton Park cannot bill the insurance for these charges, but are permitted by insurance companies to bill the patient for them. We kindly ask for 24 hours notice if you are unable to come to an appointment previously made. Notifying us 24 hours in advance allows us to offer the appointment time to others. Failure to show up for an appointment without notification is subject to a No Show charge (currently **$50.00**) Please note – reminder calls are sent out as a courtesy, it is still the patient's responsibility to keep all appointment, unless there is a 24 hours notice. **No Show fees must be paid to reschedule the appointment.**

_____**Co-Payments** are due at the time of the office visit. Failure to not pay your co-pay will result as a cancellation of your appointment.

_____**Past Due Accounts:** Accounts that are past due greater than 90 days are subject to being referred to a collection agency as well as a **$25.00** late fee charge. I understand that I am financially responsible for any balance due on my account that my insurance does not cover. I agree to reimburse Foot Care of Clifton Park the fees of any collection agency, which will be added to the account at the time it is placed with an agency for collection and be based on a percentage at a maximum of 30% of the debt, and all reasonable costs and expenses, including reasonable attorneys' fees, incurred in such collection efforts. I also understand that any overdue account balances can incur late fees and/or collection fees.

_____**Insurance Billing:** I hereby give permission to Dr. Mindy Lam of Foot Care of Clifton Park to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of my condition. I hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical and surgical care.

_____ **Returned Check Fee:** Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $**30.00** fee per check returned. After the first returned check, check payments will no longer be accepted.

PRINT NAME: _____

RESPONSIBLE PARTY SIGNATURE: _____ **Date:** _____

Patient Name (If different from Responsible Party):_____