COMPLETE FEET
& ANKLE CARE

Address: 2905 W. Warner Road Ste #20 Chandler, AZ 85224
Phone: 480-933-0801
Fax: 480-933-0476
URL: www.greggkrahndpm.com

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

1. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance.

2. This office accepts cash, checks, most major credit cards and many forms of insurance.

3. Returned checks and balances older than 30 days may be subject to bank fees, collection fees and/or interest charges of 1% per month.

4. Charges may also be made for broken appointments and/or appointments cancelled without 24 hours notice.

5. We will be happy to help you process your insurance claim form for your reimbursement. If we are contracted with your insurance company, we will submit the claims directly for you. You must realize however that:

   A. Your insurance is a contract between you, your employer and the insurance company.

   B. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We are not responsible and have no control over your insurance company's decisions.

   C. Our fees are generally considered to fall within the "UCR" by most companies. "UCR" is defined as "usual and customary, and reasonable" fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance status), I am responsible for the balance on my account for any professional services rendered to me (or my minor) by Family Foot & Ankle Care, P.C.

Patient Signature: _____ Date: _____
(Parent or Guardian if a minor)