Grants Pass Podiatry

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PODIATRIC PHYSICIANS AND SURGEONS
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WELCOME!

Welcome to Grants Pass Podiatry. We are pleased to have you as a new patient. Please feel free at any time to notify us of any way we can assist you with the medical care of your feet and ankles. When making an appointment, please try to call our office at least two weeks before you need to be seen. However, if you have an emergency, we will try to accommodate you or make sure you have an alternative for your emergency care.

If for any reason you have to cancel your appointment, please give us at least 24 hours notice. For all appointments, please be on time. If you are more than five minutes late, we will have to reschedule your appointment. You will receive an appointment reminder by phone at least 24 hours before your appointment, and we ask that you confirm your appointment with us by phone.

BILLING PROCEDURES

MEDICARE We are participating providers with Medicare. If you have supplemental insurance, we will bill that insurer for any services Medicare does not cover. If you don't have supplemental insurance, you will be responsible for anything that is not covered.

UNINSURED PATIENTS Payment for all charges is due at the time of service. We offer a 10% discount to all uninsured patients.

INSURED PATIENTS If you have insurance, be prepared to pay at the time of service for over the counter supplies and co-pays that are not covered by the insurance. We accept cash and checks only. Insurance may pay all, some, or none of your bill. After we bill your insurance and receive their payment, you will owe the balance. We will not know what that balance will be until we receive the insurance payment. You are responsible for payment in full, regardless of your coverage.

PAPERWORK FEE Disability forms, medical records and requested letters will incur a $35 paperwork fee which is due when you pick up the paperwork, unless the doctor waives the fee.

STATEMENT FEE You will receive a monthly statement of your account. A $5 statement fee will added to your bill each month after 60 days.

AUTHORIZATION

I authorize my insurance benefits to be paid directly to Grants Pass Podiatry. I understand that I am financially responsible for any balance unpaid by my insurance. I understand the above information and agree to abide by these rules.

Signature _____ Date _____