

Bruce Lashley, D.P.M., F.A.C.F.A.S.

Financial Agreement

I _____ have requested treatment from Dr. Bruce Lashley, I have read and understand the following:

1. I am responsible for all co-payments, deductibles, and co-insurance as per the terms or my contract with my insurance carrier.
2. **All co-payments must be paid at the time of service.** This includes multiple copayments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e, for injections or x-rays.)
3. I am responsible for obtaining any and all required referrals for service.
4. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until *after* the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
5. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claims for me as per the terms of the contact with my insurance carrier.
6. The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment.
7. Fees associated with orthotic casting, prepared at my request, are my responsibility. Should I choose stop the process of making the orthotics, I am still responsible for these fees, once the cast as been taken.
8. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the office's financial institution. This current rate may be obtained by calling the *Billing Manager* at 212-949-2901.

Patient Signature/Name

Guardian Signature if applicable

Date Signed