Dr. Faiza Khan, DPM
Dr. Syed H. Mohiuddin, DPM
Kinex Podiatry, Foot & Ankle Clinic
P: 972-709-7556 | F: 972-709-7611

Agreement of Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which our providers are **in-network,** if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we are **in-network (in contract)** with your insurance company we will bill your insurance company first, minus any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we are **out-of-network (not in contract)** with your insurance company, you will be expected to pay for **all services rendered** at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

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- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card **does not** confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have **out-of-network benefits** that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an out-of-network benefit, your portion of financial responsibility may be higher than the in-network rate.
- **There is a NO SHOW fee/Late Cancellation fee of $25 dollars, if you fail to show for an appointment or fail to cancel 24 hours prior to your appointment time**. Our staff sends email reminders and call reminders prior to your appointment date to help you avoid these charges.

Patient Statement of Agreement:

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

______________________________	______________________
Signature of Patient /Responsible Party	Date
______________________________	______________________
Name of Patient/Responsible Party (please print)	Relationship to Patient

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