
Dr. Claude Mayembe, DPM

Podiatric Medicine, Surgery and Wound Care.

FINANCIAL ACKNOWLEGDEMENT & AGREEMENT

**PLEASE READ CAREFULLY INITIAL, THEN SIGN BELOW:**

Your understanding of our financial policy is an essential part of your treatment. By signing this agreement, you acknowledge herewith that you have **voluntarily** entered into a financial agreement with STRIDE FOOT & ANKLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services.

_____**Insurance:** Our office works with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible or Non-Covered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services on the day of my visit

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_____**Co-Pays:** All co-payments are due **AT THE TIME** of service without exception and are your responsibility. If you do not have your co-payment, you may be asked to reschedule your appointment for a later date.

_____**Coinsurance:** Medicare will send a cross-over claim to your secondary insurance for coinsurance payment. Patients without Medicare Supplemental Insurance will receive a bill of coinsurance.
If your Medicare Advantage plan or non-Medicare plan has coinsurance, you will be billed after insurance has paid part of the claim.

_____**Uninsured patients:** if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of **$200** prior to receiving services. This amount can be paid in cash, debit/credit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed $200, payment is required at that time.

**Referral:** You are responsible for obtaining any necessary referral if required by your insurance company. If a referral is not obtained and is necessary, you are responsible for full payment.

_____ _____

Printed patient name Patient Signature/Responsible Party

_____ _____/_____/_____

Office staff Today's date