Harold D. Sterling, Jr., D.P.M., P.C.

Physician and Surgeon of the Foot

Diplomate, American Board of Podiatric Surgery
Board Certified in Foot Surgery

6452 Millennium Dr., Suite 130
Lansing, MI 48917
(517) 321-1199 • Fax (517) 321-1117

INSURANCE POLICY AND BILLING

Thank you for choosing us as your healthcare provider. We are committed to your care and treatment. The following is a statement of our financial policy which we require that you read and sign prior to treatment.

INSURANCE POLICY

As a courtesy, we will bill your insurance company for most covered services. If you fail to provide us with your insurance information, you will be given a bill and a diagnosed receipt which you may submit to your insurance company.

Please provide the receptionist with all insurance information, including current insurance cards and contract information. Our charges are usual and customary for this area. If you have any questions regarding services, charges and/or billings on a particular date or service, please contact our insurance manager.

Insurance companies take from weeks to months to reimburse our office. If we have difficulties, especially after rebilling your insurance, you will be billed so that you may deal directly with your insurance company.

You are responsible for payment of all services provided, especially deductibles and co-payments.

MEDICARE POLICY

Our office participates with Medicare, and we are required by law to file for covered services. Non-covered services, deductibles and co-payments which Medicare does not cover will be billed to you.

BILLING POLICY

Payments for non-covered services is dues at the time of the service unless other arrangements are made. We accept cash, money orders, checks and credit cards.

For balances due over sixty (60) days, a statement fee of $10.00 per statement and 9% interest, to offset the costs of statement preparation, will be charged.

Our accountant handles all accounts over ninety (90) days delinquent. If collection services become required, all attorney fees and costs will be the responsibility of the patient and/or guardian. If you have a special circumstance regarding payment, please contact our insurance manager.

I authorize the release of any medical information necessary to process my insurance claim, and I authorize the release of medical information to my family physician.

I HAVE READ AND AGREE TO THE ABOVE POLICY

_____ _____

Patient's Signature (Guardian, if minor) Date