Foot & Ankle
Center of Arizona

KRIS DINUCCI, DPM
7312 E DEER VALLEY RD #110
SCOTTSDALE, AZ 85255

PATIENT FINANCIAL RESPONSIBILITY POLICY

- REFERRALS- If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not obtain your referral, you will be responsible for the visit charges in full at the time of the service.

- APPOINTMENTS- As a courtesy, we attempt to contact every patient to remind them of their appointment. We kindly ask you to notify us 24 hours in advance in the event you cannot keep your appointment.

- INSURANCE- Your insurance policy is a contract between you and the insurance company. As a courtesy we will file your insurance claim for you. This allows insurance company to pay the doctor office directly.

- CO-PAYMENTS & DEDUCTIBLES- Our policy is to collect your portion of the insurance designated co-payment/ co-insurance/deductible payments at the time of service. Please be prepared to pay at your visit. We accept VISA, MC, DISCOVER, AMEX, CASH OR CHECK.

- OUT OF NETWORK BENEFITS- If we do not participate with your plan but you would like to be treated in our office, we will send a courtesy bill to that carrier on your behalf. Patients are responsible for the co-pays, co-insurance and deductibles at the time of the service. Should your insurance not pay the claim you will be responsible with the full amount due. If you receive a payment from the insurance company directly, please forward it to the physician's office.

- SURGERY PATIENTS- Surgical procedures might require a pre-payment of deductible and co-Insurance payments if applicable. You will be informed if this applies to your surgery. Surgery date change/cancellation fee is $250.00 once it is scheduled with the facility.

- DELINQUENT ACCOUNTS- Past due accounts are subject to collection proceedings if unpaid after 90 days without further notice. In the event your account is turned over to collections, you are responsible for all associated collection costs and late fees.

- RETURNED CHECKS- Returned checks are subject to $25.00 fee.
  THANK YOU FOR TAKING THE TIME TO REVIEW OUR POLICIES. IF YOU HAVE ANY QUESTIONS PLEASE DISCUSS THEM WITH OUR FRONT OFFICE STAFF OR MANAGER.

  Signature of Patient/ Responsible Party: _____

  Name of the Patient/Responsible Party: _____