Grossman Podiatry Center

family footcare since 1932

Important Office Policies

This office strives to have a clear understanding of the following policies.

Please initial by statements.

(initial)_____ 1. I agree to let this office know when I will not be able to make an appointment. I understand that I may be charged $25 if I do not notify the office. I understand that I will not be able to reschedule with this office if I chronically miss appointments.

(initial)____ 2. I agree to pay my co-pay the day of appointment as per my insurance company regardless of the amount. I understand that I may be asked to pay balances due to this office prior to being seen. I understand that if I have a delinquent balance I will be unable to reschedule until it is paid.

(initial)_____ 3. I understand that I am ultimately financially responsible for my visit with this office today. I understand that this office cannot know with certainty until it files a claim on my behalf to my insurance company whether the visit will be covered and what amount may be due.

I agree to the above policies as indicated by my initials.

Name: ____ Date: ________________

Guardian (if necessary): ____

Signature: ____