2700 Old Rosebud Rd, Suite 110
Lexington, KY 40509
www.lexpodiatry.com

LEXINGTON PODIATRY
the foot and ankle specialists

Ph 859-264-1141
Fx 859-264-1963
happyfeet@lexpodiatry.com

Patient Resource Guide for Billing and Insurance Information

Payment Policies

Customer Service
Customer service phone lines are open daily from 8:00 a.m. to 5:00 p.m. You can reach a customer service representative with questions regarding account balances by dialing our local Lexington number.

Local: 859-264-1141

Check In
The registration process is essential to ensuring accurate claims submission to your insurance and promotes timely and appropriate payment of services. For proper registration, please arrive 15 minutes early. If this is your first visit to Lexington Podiatry, please arrive 30 minutes prior to your scheduled appointment. Upon every visit with a Lexington Podiatry provider, the check-in desk registrar will:

- Verify your address, telephone number and email address
- Make sure all proper forms are filled out
- Ask to see your most current insurance card(s) and photo ID

These basic steps are the most important steps you can take to avoid delays at check-in and are performed at each visit.

Plan Participation, Network Requirements and Benefits
To verify our participation with your insurance plan, please contact your insurance carrier, your employer or our customer service department prior to your appointment. Patients are strongly encouraged to verify their plan benefits and network requirements prior to their visit. This helps patients to avoid incurring unexpected financial responsibilities for the services they seek.

Pre-Authorization
Many insurance plans require prior authorization for hospital admissions and certain outpatient procedures or tests. In some instances, your physician may be aware of these requirements and will proceed with obtaining the proper authorization. However, it is impossible to know these requirements for all insurances and procedures. It is important that you check with your insurance carrier to verify if your procedure or test requires authorization and let your physician know. Claims denied for lack of pre-authorization may be billed to the patient.

Medicare
Lexington Podiatry is pleased to be a participating provider in the Medicare Program and will file claims for Medicare beneficiaries. Any deductibles, co-insurance or non-covered services are the responsibility of the patient. If there is a supplemental coverage available, Lexington Podiatry will file a claim to the second carrier as a courtesy. However, follow-up with the supplemental carrier, as well as amounts not paid, are the responsibility of the patient. Medicare does not always cover all services. There are certain types of routine care, as stated in the Medicare benefits, which may not be covered.

Medicare patients should expect to be responsible for these services. There may also be some diagnostic tests that Medicare may not cover. This does not mean that these services are not an important part of the healthcare being provided to you. Lexington Podiatry participates with many of the Medicare advantage plans or Medicare replacement plans including Humana Medicare plans. Please contact our offices to verify if your Medicare Advantage plan is accepted.

HMO/PPO and Other Participating Plans
Lexington Podiatry participates in a variety of HMO, PPO and commercial plans. Due to the large number of plans, Lexington Podiatry does not have the benefit details on each plan. It is important for patients to always check with their carrier or their benefits booklet before being seen to confirm the following information.

- Is the doctor or facility being utilized covered by your plan?
- Is a referral or authorization necessary for the services to be covered?
- How much out-of-pocket expense will you owe for a visit to that provider?

At the time of your visit, you will be responsible for making any co-payment or other known out-of-pocket expenses. In most cases, Lexington Podiatry will file your claim and once processed, any additional amounts not covered by your plan will be billed to you. Payment will be due upon receipt of you statement. Examples of these amounts include additional co-payments mandated by your plan, deductibles, co-insurance or non-covered services as outlined by your policy.

Workers' Compensation
Lexington Podiatry provides workers' compensation related services within several departments. When scheduling your appointment, please notify the receptionist that your visit is related to a work injury. In order to file your workers' compensation claim, we are required to obtain the following information:

- Employer name, address, phone number and an employer contact
- Date of Injury
- Claim Identification number and/or employer authorization
- Name of workers' compensation insurance company
- Claim address and phone number
- Insurance contact

This information may be obtained at the time of your visit or by phone. Attempts will be made through your employer to verify authorization for your visit. Patients seen for work related injuries who are unable to provide the required information, or for whom the employer has not provided us with authorization, may be asked to make payment for their services.

Motor Vehicle Accident Related Services
Lexington Podiatry will submit a claim to your auto carrier when you provide the following information at the time of your visit:

- Date of accident
- Complete name and claim address of auto insurance
- Claim number

As a further courtesy, Lexington Podiatry will allow up to 30 days for the auto carrier to make payment on your claim. At the end of the 30 days, you will be responsible for the unpaid balance. You are encouraged to remain in contact with your agent or the auto insurance carrier regarding the status of your claim(s), as well as the benefits of the plan, including any deductibles, policy limits or exclusions. Patients seen for motor vehicle related services who do not provide us with the appropriate information to file the claim will be asked to pay for service in full at each visit.

Other Insurance
You may carry a commercial group plan that does not fall into one of the other categories. In most cases, as a service and courtesy to you, Lexington Podiatry will file your initial claim on your behalf.

You may be asked upon arrival to make a payment towards your anticipated out-of-pocket amounts such as deductibles or co-insurance. Any amounts unpaid by you and your insurance after the claim has been processed will be billed to you. You are encouraged to contact your insurance carrier prior to your visit to confirm your benefits.

Uninsured Patients
Lexington Podiatry welcomes patients without insurance coverage, to help offset the cost we will offer a prompt pay discount. Uninsured Patients will be asked to pay their balance in full at each visit.

Financial Policies

We would like to take this opportunity to review the Lexington Podiatry Financial Policies with you, our valued patient.

Insurance Billing and Coverage
Lexington Podiatry is contracted with and accepts most local insurance plans, but not all. As a service to our patients, we will file eligible claims to most plans. We do not files claims to specific non-participating HMO plans or to plans outside of the USA. Prior to your service you should always consult your insurance carrier or your benefit booklet for a list of providers and benefits available to you. This will allow you to verify the services and if the provider you seek will be covered, identify any authorization requirements or exclusions, and also the level of benefit available. Many plans will provide some level of coverage to providers not listed in their network. Because coverage determinations are ultimately made by the insurance company, we are unable to guarantee their payment. Therefore, it is necessary that you be aware of the details of your coverage before obtaining care.

Insurance Follow-up
Lexington Podiatry strives to always provide accurate and timely billing to insurance companies and to patients. In most cases, claims are filed and processed by the insurance company within 30 days. Any unpaid balances are billed to the patient within 60 days from the date of service. However, on occasion, a carrier may not respond immediately and further attempts to obtain payment from your insurance company may be required. In such instances, payment from the carrier may take longer than usual and you may be billed for amounts not covered by the plan at a later date.

Our offices generally make two or more attempts for payment from the group carrier. Occasionally, a claim may remain unpaid by insurance even after repeated efforts by our billing office to resolve it. In such cases, the unpaid balance may then be billed to you with an indication to contact your carrier regarding questions about the payment of your claim. This is not our preferred method of billing. However, we have found that with the assistance of the patient in these instances, the claim is often resolved fairly quickly by insurance. If not resolved by insurance, then the claim will become the responsibility of the patient.

Referrals and Authorizations
Most plans clearly publish their referral and authorization requirements. Please ensure that your primary physician has forwarded a copy of your referral to our office or bring a copy with you to your first appointment. You should also inform our office of any authorization requirements your plan has prior to your appointment. Usually this can be communicated at the time of appointment scheduling. Our office will then seek verification that your plan has authorized your treatment. If referral is not obtained before your appointment you will be responsible for all payment on all services performed.

Account balances
Co-payments and services not covered by insurance are due in full on the day of your appointment. Account balances, estimated deductibles and co-insurance amounts may also be requested when you check in, if this information was available prior to your appointment. Any amounts not covered by your plan, and not collected on the day of service, will be billed to you and are due in full upon the receipt of your statement. Patients will receive a billing statement each month for balances that are due from them. The bill is itemized and will reflect the cost of service. Payment is due in full by the date indicated on the statement. Questions about this amount can be obtained by contacting Lexington Podiatry.

Partial Payment
Although payment in full is expected, partial payments can be arranged through our customer service department. Monthly amounts are based upon the size of the balance and generally start at $50.00/month. The larger the account balance, the larger the monthly payment will be. For your convenience, you can also make payments through our website on account balances. It is important that patients wishing to make partial payments contact Lexington Podiatry for payment plan options.

Payment options
Account payments can be made at the time of registration, in person at our location, through the mail, over the phone or online at lexpodiatry.com. Unfortunately we are unable to accept checks from our self-pay patients. There will be a $30.00 returned check fee applied when applicable.

Payment methods include:

- Check
- Cash
- Credit/Debit Cards
- Care Credit
- Extended Payments Upon Approval

Cancellations
Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Patients who fail to cancel a scheduled appointment for our laser or with a physician will be charged a $50.00 no show fee.

Cancellations for scheduled surgery must be received at least 10 days prior to the scheduled surgery date. Patients who fail to cancel a scheduled surgery within the allotted time frame will be charged a $250.00 no show fee.

Delinquent Accounts
Accounts that remain unpaid after 30 days will be treated as delinquent and efforts will be made to collect unpaid balance. These efforts may include phone calls, letters and possible referral to an outside collection agency. It is our sincere desire to avoid outside collection agencies. As such, a notice will be mailed to the last known address on the account prior to any referral. Patients are strongly encouraged to work with our business office on suitable payment arrangements to avoid placement of their account with an outside agency. In the event that your account is turned over to an outside collection company a fee totaling 35% of your account balance will be added to your total outstanding charges.

Care Credit
Care Credit is a national credit card that can be used at participating medical and dental facilities. It allows individual and families to manage their medical expenses on a single credit card. To apply for a Care Credit card, you can contact our office for an application or long onto their website at www.carecredit.com

Frequently Asked Questions

How can I obtain my medical records?
Contact Lexington Podiatry at 859-264-1141

How do I find answers to billing questions?
Our knowledgeable team is happy to assist you with your billing questions. You may reach us at 859-264-1141 Ext. 53 Monday-Friday between the hours of 8 a.m. and 5 p.m.

What is a "screening" or "routine" service, and why won't my insurance company pay for it?
"Routine" or "screening" services are provided in the absence of a disease, condition, or relevant symptoms. In other words, there is no medical condition that prompts performance of the service.

These services are vital for early detection of many medical conditions and are very important for your care; however, this does not guarantee that your insurance company will cover them. If your insurance policy does not cover these types of services, you may become responsible for payment. We recommend you contact your insurance company to find out what type of "screening" coverage you have.

My insurance company told me if the claim had been filed differently than the service would have been covered. Why can't you change the way my claim was billed?
Medical billing is a regulated and monitored by the government. The guidelines are very clear regarding how to properly code. A doctor must always accurately indicate the service or test performed as well as the precise reason it was performed. For instance, if you came in for an exam, your physician may perform several services or tests in order to diagnose or monitor different medical conditions. This means that it is possible not all of your services will have the same diagnosis code (reason) on the same day. Some services are routine in nature, while others may be ordered to follow-up on an established condition. Because many plans have different benefits available depending upon the reason for the service, it is possible that they will pay differently on one or more services performed on the same day. Although it may be true that your insurance would have paid differently under a different diagnosis, a diagnosis cannot be changed for the sole purpose of obtaining benefit coverage. The diagnosis must reflect the true reason the services was performed.

If you feel the diagnosis indicated on your claim is incorrect, our staff of experienced, certified coders will review your claim for accuracy and make changes as supported by medical documentation.

Does Lexington Podiatry accept my insurance?
Lexington Podiatry is contracted with and accepts many local insurances. Please refer to your benefit or provider booklet for a list of doctors available to you and to verify your benefit coverage. Your plan may even provide a level of coverage for doctors not listed.

Why must I show my insurance card at every visit?
Insurance companies supply identification cards which are to be presented by the patient for all services. Insurance companies will sometimes update the cards with new information. Even though your coverage may not have changed, sometimes important filing data on the card has changed. Lexington Podiatry strives to submit claims on your behalf in both a timely and accurate manner. In order to avoid delayed payment and possible non-payment of claims, verification of coverage is required each time you arrive.

Why am I receiving a statement from another laboratory that I have never been to?
There may be some test that we are not equipped to handle internally. In such cases, the test may be forwarded to another lab for completion. Insurance information will be sent along with the specimen to assist with proper billing of your test.

I handle all the bills in my family; so why can't someone in the central business office talk to me about my spouse's account?
Federal HIPPA laws set forth to protect the confidentiality of patient medical information prohibits Lexington Podiatry from disclosing information without the consent of the adult patient. Detailed information can be discussed with a spouse once proper permission has been

obtained. Please contact Lexington Podiatry to obtain an authorization form or you may complete an electronic version upon registration.

I have an H.S.A. (or H.R.A.) plan. Do I need to pay when I come in?
Health Savings Account (H.S.A.) and Healthcare Reimbursement Account (H.R.A.) plans generally have higher deductibles and out-of-pocket costs. As with any deductible plan, you may be asked to make a pre-payment on services which are expected to apply towards your deductible. You can submit your receipt through your H.S.A/H.R.A. account for reimbursement if eligible expenses. Patients who have been issued H.S.A/H.R.A debit cards may be able to use these cards to access funds to cover these pre-payments at the time of payment.

Why does the website reject my Care Credit card payment?
The website can be used for Visa, MasterCard, Discover, or American Express credit transactions, as well as checking account payments. The Care Credit card requires a special terminal linked directly to that company. Payments made by Care Credit can be made in person or by calling our office.

Glossary of Insurance Terms

Allowable: The maximum amount the insurance company will allow on a specific service. For example, if your insurance plan pays 80 percent, then the payment will be 80 percent of the allowable that they have contracted, rather than 80 percent of the charge amount.

Ancillary service: These are services such as lab tests, X-rays, and other testing performed by technicians or other doctors at the request of your physician. Patients may not actually meet the physician in charge of interpreting their tests. These services are billed separately and in addition to your ordering physician's charge.

ASC: *Ambulatory Surgery Center*-This is a facility in which outpatient procedures may be performed. In addition to the surgeon's fee for the surgery, the ASC will also charge a fee for the facility.

Benefit: The amount paid by the insurance company towards specified services. Also known as the insurance plan payment, payment amount or paid to provider.

Charge: The total amount billed by your provider for the service rendered. Each service has its own charge amount which is the same regardless of the amount allowed by the insurance.

COB: *Coordination of Benefits*- When another insurance company has paid, the next insurance may lower their payment to coordinate with the first. This avoids overpayments of claims or patients making money from a visit to the doctor.

CPT code: A code that describes the type of service that was performed by the physician. Also known as a procedure call.

Co-insurance: A percentage of the total cost for a provider's service that the patient is responsible for paying as defined by their insurance plan benefits. Co-insurance does not include deductibles, co-payments or non-covered expenses.

Co-payment: This is a specified amount, predetermined by the insurance company that the patient must pay at each visit. Most insurance plans require a co-payment for tests such as labs and X-rays. Co-payments are due at the time of service.

Deductible: The deductible is the minimum amount determined by the insurance plan that the patient is responsible for paying each year. Patients usually must meet their deductible before the insurance company will pay for services and is in addition to any co-insurance that may be required.

Deposit: A deposit is an amount that is required to be paid by a patient towards their services in advance. It is often a partial payment since it is impossible to always asses what services or tests will be required before the physician has seen the patient. Any amounts in excess of the deposit amount will be billed to the patient.

Disallowed: The amount above the allowed charge. This is the amount that is patient due for non-participating insurance plans and considered the adjustment/discount for participating insurance plans.

Discount: The amount that the provider and the insurance have agreed upon as the maximum allowed amount for the charge and for which the provider has agreed to lower the bill to meet. Discounts are also referred to as provider discounts, contractual adjustments or provider write-offs. When the insurance company and the doctor have a contract, these discounts are accepted. These are considered participating insurances.

EOB-*Explanation of Benefits*- The statement provided by the insurance company explaining what charges were processed, how they were processed and how much was paid. Also described as a remittance, EOMB, explanation of medical benefit or explanation of payment.

HMO-*Health Maintenance Organization*- Insurance plans with strict usage guidelines. Care is coordinated within the network by the PCP, primary care provider. Non-emergency, out-of-network care is usually not covered. Specialist visits and tests usually require special authorization. Patients are required by their plan and their doctor to know their own benefits.

H.S.A/H.R.A: *Healthcare Savings Account or Healthcare Reimbursement Account*- Funds are placed into these accounts by the employer and/or the employee to cover higher deductibles and co-insurances for covered expenses. Funds are available only up to the limit of available funds within the account and may not cover the entire deductible or other out-of-pocket expenses.

Medicare replacements: Medicare replacement polices (also called Medicare HMO's, Medicare Advantage Plans and Medicare Private Fee-For-Service plans) are policies that cover Medicare eligible patients who have elected to withdraw from Medicare coverage in favor of a private plan with different benefits. These are not Medicare supplemental policies. Lexington Podiatry will accept and file most claims for Medicare replacement plans. Patients presenting for care with non-participating policies will be required to pay for services rendered.

Medicare supplement: A plan which is purchased by the patient to specifically cover the co-insurance amounts not paid by Medicare. Many supplements will also pay the Medicare deductible and some plans will pay a few of the services not covered by Medicare. However, most services that Medicare does not cover are also covered by the supplement.
Non- covered Service: This is a term used by insurances to indicate a service is not eligible for benefits under your policy.

Non-participating: An insurance company that does not have a contract with the provider. The patient owes all amounts not paid by the plan, including amounts considered to be not "allowed". Sometimes this is listed as non-covered or provider responsibility, but due to the lack of contract, the patient is responsible for the amount as well.

Participating: When a provider has entered into a contractual arrangement with an insurance plan, they are said to "participate" with that plan. They may be referred to as a "network" or participating provider. This contract states the physician has agreed to accept the insurance company's allowable and will lower the bill to meet that amount. Doctors do not participate in all plans. It is very important that patients know if their provider is in their network and participates with their insurance plan. Benefits may be paid differently for network providers compared to non-network. Generally, the patient owes less if they see a doctor that their plan has established as participating in their network.

Patient due: The amount due from the patient deductibles, co-insurance, non-covered services or non-participating disallowances. Also known as patient liability or member responsibility.

PCP: *Primary Care Provider*- The patient's family doctor. When designated by an HMO type of insurance plan, this will be the only provider who can treat or refer the patient for tests or specialist care. Generally, PCP providers will practice in an Internal Medicine, Family Medicine, General Practice or Pediatrics department.

Pending: The term pending is used to describe services that have been billed to the insurance carrier, but the provider has not yet received a response or payment.

PIP: *Personal Injury Protection*- The benefit paid under your automobile insurance policy for your covered medical services due to an accident.

PPO*: Preferred Provider Organization*- A type of insurance plan that covers both network and non-network services. These plans usually encourage in-network visits by discounting these services. Patients will owe less if they see a network physician compared to a non-network physician. This type of plan may also have special authorization requirements for specific types of care. This plan and the provider require that the patient's know and abide by these requirements in order to obtain maximum coverage.

Pre-Existing: This refers to a clause within many insurance policies that does not allow payment of claims for specific illnesses which were present prior to the effective date of the plan. Such a clause generally expires within 6-12 months after enrollment in the plan. This means that such services incurred after the clause has expired may later be covered. The patient will owe for any services denied as pre-existing.

Pre-Payment: A pre-payment in an amount, required from patients who have insurance, that will be applied towards estimated out of pocket expenses such as deductibles, co-insurance or non-covered services. Pre-payments are due at the time of service. Any amounts that are the patient's responsibility in excess of the prepayment will be billed to the patient after the insurance has processed the claim(s).
Provider: Any doctor, healthcare professional or facility can commonly be referred to as a healthcare provider.

Specialist: A doctor or healthcare professional, other than a PCP, with an area of expertise outside of pediatrics, family medicine or internal medicine.

Subscriber: The subscriber is the primary member or "holder" of an insurance plan. If the insurance is provided through an employer, the subscriber will be the enrolled employee.

UCR: *Usual and Customary Rate*- Also known as the allowable amount. This is the amount that the insurance has determined to be their maximum allowable for the charge. Generally, any amounts above the UCR is due from the patient as the provider has not agreed to accept the insurance's fees.