PATIENT FINANCIAL POLICY

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

THANK YOU FOR CHOOSING ELITE FOOT & ANKLE CENTER PC AS YOUR HEALTH CARE PROVIDER. WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. PAYMENT OF YOUR BILL IS CONSIDERED A PART OF OUR PROFESSIONAL RELATIONSHIP AND A CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT.

INSURANCE IS A MEANS OF PAYMENT BUT DOES NOT RELIEVE YOU FROM FINANCIAL RESPONSIBILITY. TYPICALLY, INSURANCE COMPANIES SHARE THE COSTS WITH YOU IN THE FORM OF CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE AMOUNTS. THESE AMOUNTS VARY WIDELY BETWEEN INSURANCE COMPANIES. BECAUSE YOUR INSURANCE CONTRACT IS BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY WE ENCOURAGE YOU TO TAKE AN ACTIVE ROLE IN UNDERSTANDING YOUR BENEFITS AND OUT OF POCKET EXPENSE. ULTIMATELY, PAYMENT OF OUR BILL FOR SERVICES IS YOUR RESPONSIBILITY.

WE PARTICIPATE WITH MOST MAJOR PAYERS WHICH MEANS THAT COVERED CHARGES WILL BE PAID DIRECTLY TO US BASED UPON YOUR BENEFIT PLAN. IF WE DO NOT PARTICIPATE IN YOUR INSURANCE PLAN, YOU MAY STILL CHOOSE TO BE SEEN BY THE PRACTICE AND YOUR CLAIM MAY BE ELIGIBLE FOR "OUT OF NETWORK" BENEFITS WHICH TYPICALLY RESULT IN ADDITIONAL OUT OF POCKET EXPENSE. AS A COURTESY TO YOU, WE WILL FILE A CLAIM WITH YOUR INSURANCE CARRIER ON YOUR BEHALF. ANY REMAINING BALANCE WILL BE BILLED TO YOU.

WE REQUIRE YOU TO PRESENT PROOF OF INSURANCE AT EACH MEDICAL VISIT. IF WE ARE UNABLE TO VERIFY YOUR INSURANCE OR YOU DO NOT HAVE YOUR INSURANCE CARD, YOU WILL BE CONSIDERED A SELF-PAY PATIENT AND PAYMENT WILL BE DUE AT TIME OF SERVICE. INSURANCE STATUS PRESENTED AT TIME OF SERVICE WILL BE CONSIDERED THE FINAL STATUS FOR THAT VISIT AND RETRO-ACTIVE CHANGES ARE NOT PROCESSED.

CONSISTENT WITH INSURANCE REGULATIONS, CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE AMOUNTS ARE DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AND OFFER PATIENT FINANCING OPTIONS FOR YOUR CONVENIENCE. ADDITIONAL FEES, WHICH ARE TYPICALLY NOT COVERED BY YOUR INSURANCE PLAN WILL BE CHARGED FOR SERVICES SUCH AS COPYING MEDICAL RECORDS, COMPLETION OF DISABILITY FORMS, AND NON-COVERED MEDICAL SERVICES.

A FEE OF $25.00 WILL BE CHARGED FOR CHECKS RETURNED FOR INSUFFICIENT FUNDS. ADDITIONALLY, A $25.00 FEE AND INTEREST UP TO 18% PER ANNUM WILL BE CHARGED ON ALL ACCOUNTS WITH DELINQUENT BALANCES. AS MUCH AS WE HOPE TO AVOID COLLECTION ACTIVITY, WE MUST INFORM YOU THAT DELINQUENT ACCOUNTS MAY BE ASSIGNED TO A COLLECTIONS AGENCY AND ALL COLLECTION COSTS WILL BE ADDED TO YOUR OUTSTANDING BALANCE. PATIENTS WITH DELINQUENT ACCOUNTS MAY BE DISMISSED FROM OUR PRACTICE. YOU MAY BE CHARGED A FEE OF $50.00 FOR MISSED APPOINTMENTS NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE. MULTIPLE MISSED APPOINTMENTS MAY RESULT IN TERMINATION FROM THE PRACTICE.

I CERTIFY THAT THE INFORMATION THAT I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO MY INSURANCE COMPANY TO DETERMINE BENEFITS FOR SERVICES RENDERED. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE PAYABLE DIRECTLY TO ELITE FOOT & ANKLE CENTER PC ON MY BEHALF. I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ THE ABOVE PATIENT FINANCIAL POLICY AND HAVE PROVIDED THE PRACTICE WITH TRUE AND CORRECT INSURANCE INFORMATION. FINALLY, I WILL NOTIFY THE PRACTICE PROMPTLY OF ANY CHANGES IN MY HEALTH INSURANCE COVERAGE.

_____ _____/_____/_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN/HEALTHCARE POWER OF ATTORNEY *DATE*