family foot docs

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to family foot docs all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____ _____

Responsible Party Signature Date

_____

Relationship

HIPPA Privacy Act

I have reviewed the notice of the Privacy Practices and have received or declined a copy for my records at this time.

X_____

Signature

Financial Policy

We at family foot docs are committed to providing you with the best possible foot care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our office payment policy. I do acknowledge that the office requests **24 hour cancellation notice**. Otherwise, family foot docs reserve the right to charge for time reserved. I will update my information yearly or on a regular basis, along with supplying a valid insurance card and photo id/driver's license at the time of my appointment. All co-pays are due at the time of service. I will supply any changes to my demographics, employment, or emergency contact. Family foot docs accept payment of check, cash or credit card and insufficient funds or balances over 30 days are subject to additional collection fees. They will file my insurance as a courtesy, but it is my responsibility to pay any unpaid insurance balances. There is a **$25 form fee** for any FMLA/Disability forms, and I must allow at least 3 business days for these forms to be completed by the physician. I accept and acknowledge that, should I need to request a copy of my medical records, a release form from family foot docs' office or a written letter with my signature is required and a **$25 medical records fee** will be collected at the time of request. I must allow 3 business days for information to be ready for pick up or mailing. No original records will be released. Digital X-Rays are performed at family foot docs and copies are available upon medical records request and will follow same guidelines as such. All X-Rays films are property of family foot docs and can be released to myself, but they must be returned to family foot docs in 15 days and a $100.00 deposit will be held at the time of pick up. HMO Patients—If my insurance requires a referral from my Primary Care Physician, that referral must be presented at the time of my visit, or family foot docs will not be able to provide service at the time of my appointment. If I do not have the referral form and choose to be seen, I will be responsible for paying any fees at the time of the appointment. **All balances and any portion left unpaid by my insurance is my responsibility. Delinquent accounts sent to collections will have a collection fee attached. All collection accounts must be paid in full before future care at this office is rendered.**

X_____ _____

Signature Date