family foot docs

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage 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 including, but not limited to deductibles, coinsurance and co-pays, whether paid by insurance or not. 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 _____

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 Please **initial** on the lines below that you have read and agree to each statement prior to receiving treatment from our providers.

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. It is your responsibility to know and understand your insurance policy benefits.

____ I do acknowledge that the office requests 24-hour cancellation notice. Otherwise, Family Foot Docs may reserve the right to charge for time reserved.

____ Family foot docs accepts 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

____ All past due balances and collections accounts must be paid in full before future care at this office is rendered.

____ 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. I must allow 3 business days for information to be ready for pick up or mailing. A medical records fee may apply.

____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.

____ **FOR MEDICARE PATIENTS ONLY** I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by family foot docs. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

X Signature _____ **Date** _____