Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or office manager.

- As our patient, you are responsible for all authorizations and referrals needed to seek treatment in this office
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash, or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay, co-insurance, or deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all the charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines services to be “not covered,” or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization or referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- **There is a $25.00 NO SHOW FEE for missed appointments. Your insurance company does not cover this. After 2 NO SHOWS, a deposit of $50.00 is required to schedule any subsequent visits. The deposit will be refunded to you by check via mail less any outstanding patient balance if you show for your appointment. If you fail to show for the appointment, the $50.00 will not be refunded. Your insurance company does not cover this.**

Assignment of Benefits

I, the undersigned, certify that I or my dependent have coverage with______________________________
and assign directly to **Advanced Foot & Ankle Surgeons, Inc.** all insurance benefits, payable to be for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION TO MY INSURANCE CARRIER OR PHYSICIAN to provide continuity of care. I authorize the use of my signature on all insurance submissions. By my signature I acknowledge review of this policy and hereby agree to its terms.

Signature of Patient/Responsible Party:____

Printed Name of Patient/Responsible Party:____________________________________ Date:___________________

Medicare Assignment of Benefits

I assign Medicare payments directly to **Advanced Foot & Ankle Surgeons, Inc.** I authorize the release of medical information to Medicare in the event they request medical records for the processing of a claim. I authorize the use of my signature on Medicare claims submissions. By my signature I acknowledge review of this policy and hereby agree to its terms.

Signature of Patient/Responsible Party:____

Printed Name of Patient/Responsible Party:_____________________________________ Date:__________________