Financial and Lifetime Authorization

Thank you for choosing Family Foot and Ankle to meet your medical needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy, which we request you read and sign.

Missed appointments:

Any Established patient that does not show for their appointment, our policy is to charge $50.00. Any New Patient that does not show for their appointment, our policy is to charge $100.00. Appointments cannot be rescheduled until payment is received in the office. Patients may be discharged from the practice after 3 no-show appointments.

Minor patients:

Patients under the age of 18 MUST be accompanied by a legal guardian or treatment will be denied.

Payment for service is due at time services are rendered:

We accept cash, personal check, MasterCard, Visa, and Discover. Returned checks less that $50.00 are subject to a service charge of $25.00. Check between $50.00 and $300.00 are subjected to a service charge of $30.00. Checks greater than $300.00 are subjected to a service charge of $40.00 and you will also loose your privilege to write a check in our office.

Release of information:

I, the below named patient, do hereby authorize Family Foot and Ankle to release any third payer (such as an insurance company or government agency, example: Blue Cross of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatments and/or diagnosis.

Physician Insurance Assignment:

I, the below named subscriber, hereby authorize payment directly to family Foot and Ankle for their services as described but not to exceed the reasonable and customary charges for these services.

Medicare:

Patient's certification authorization to release information and payment request:

I certify that the information given by me in applying for payment under Title XVIII/XIX of the SSA is correct. I authorize any holder of medical or other information about me to release to the SSA Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I permit a copy of this Authorization and Assignments to be used in place of the original which is on file at the physician's office. The assignment will remain in effect until revoked by me in writing.

Commercial insurances:

Copayments and deductibles must be paid at time of service. We are under contract with most insurances and will file your insurance.

Medicare:

We are Medicare Providers and will file your claim. We will file with MOST secondary insurances. If you have any questions please check with the front desk.

Financial agreement:

We will gladly discuss for proposed treatment and do our best to answer any questions relating to your insurance. You must realize that your insurance is a contract between you and your insurance company. We are not part of that contract. Not all services are a covered benefit.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not suitable for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it is my responsibility to pay and deductible amount, co insurance or any other balance not paid for by my insurance or third party payer within a reasonable period of time. Collection action will be taken on any balances over 90 days. If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable cost of collection, including attorney fees.

Patient signature: _____ Date: _____