FREMONT FOOT AND ANKLE

FINANCIAL POLICY AND OFFICE CONSENT

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

CO-PAYMENTS & DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment/deductible at each visit.

NON-COVERED SERVICES: Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

PATIENT BILLING: We accept the following payment methods: Cash, Check, VISA/Mastercard, and Care Credit. An additional $35.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

NONPAYMENT: Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A re-billing charge of $10.00 per month will accrue on all accounts over 60 days past due. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

OTHER OFFICE POLICIES

MISSED APPOINTMENTS: Our policy is to charge $35.00 for missed appointments not canceled within a reasonable amount of time (24 HOURS) or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

IN-OFFICE PRODUCT SALES: Our in office products that are for sale by their very nature are not returnable. **All sales are final.**

MEDICAL INFORMATION: By signing this consent form you are agreeing that your provider at Fremont Foot and Ankle may request/access some medical information that may include but not limited to your prescription medication history, imaging results/reports, lab orders/results and other pertinent information from other healthcare providers and/or pharmacies that may be required to ensure proper safety and optimised your medical care. This information will be used for medical decision making and treatment.

TREATMENT AGREEMENT: I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

ACKNOWLEDGEMENT OF RECEIPT: Notice of Privacy Practices (HIPPA)
I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The Foot and Ankle Specialists of Colorado HIPAA rights are also posted in www.fremontfootandankle.com

AUTHORIZATION OF PAYMENT: I hereby assign all Medical benefits directly to ***Foot and Ankle Specialists of Colorado, PLLC*** for the payment of any services rendered. I also authorized release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

OUR COMMITMENT TO YOU: We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. Our fees are representative of the usual and customary charges for our area. If you have any questions, please discuss them with our front office staff or supervisor.

Patient's Name: ___________________________ Signature: __________________________ Date: __________

Guardian Name: ___________________________ Signature: __________________________ Date: __________

Office Witness: ____________________________ Signature: __________________________ Date: __________

________ Patient initials to indicate copy received