Patient Financial Responsibility Agreement

Thank you for choosing Active Foot & Ankle Center as your place of podiatric care. We are committed to your treatment being successful. Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please address them to our front office staff or office manager. The following is a statement of our Financial Policy, which must be read and signed by each patient and will remain in effect for all services rendered during your time as a patient at Active Foot & Ankle Center.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.

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 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 have to 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, and/or deductible at the time of service. If no co-payment is made at time of service, a $15.00 charge may be assessed.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim on your behalf on an unassigned basis. This means you are personally responsible for your bill and your insurer will send the payment directly to you. Therefore, all 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 a service to be "not covered," or you do not have 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 service rendered.

You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

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 this office.

There is a service fee of $30.00 for all returned checks and future payments will be expected in cash, money order or credit card. Your insurance company does not cover this fee.

We reserve the right to charge a fee for *missed appointments* that are not cancelled with a 24 hour notice at the rate of $35.00. Please help us serve you better by keeping scheduled appointments.

Signature of patient/responsible Party:_____ **Date:**_____

Witness: _____ **Date:**_____