

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing the Foot & Ankle Center of Arizona for your care. This financial policy is an important part of your care. Due to increased insurance company demands, we ask you to read and agree to the following provisions:

REFERRALS – If your insurance plan requires a referral from your primary care physician, it is **your** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not obtain your referral, you will be responsible for the visit charges in full at the time of service.

APPOINTMENTS – As a courtesy, we attempt to contact every patient to remind them of their appointment. We kindly ask you to notify us 24 hours in advance in the event you cannot keep your appointment. A \$50 fee will be incurred by you in the event of a No-SHOW or a cancellation made less than 24 hours before your appointment time.

INSURANCE – Your insurance policy is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. This allows the insurance company to pay the doctor's office directly.

CO-PAYMENTS & DEDUCTIBLES – Our policy is to collect your portion of the insurance designated co-payment/co-insurance/deductible payments at the time of service. Please be prepared to pay at your visit. We accept VISA, MASTERCARD, AMEX, DISCOVER, CASH, OR CHECK.

OUT OF NETWORK BENEFITS – If we do not participate with your plan but you would like to be treated in our office, we will send a courtesy bill to that carrier on your behalf. Patients are responsible for co-pays, co-insurance and deductibles at the time of the service. A paid receipt will be provided to you to submit to your insurance company. Should your insurance not pay the claim, you will be responsible with the full amount due. If you receive a payment from the insurance company directly, please forward it to our office if you have an outstanding balance.

SERVICES NOT COVERED BY YOUR INSURANCE PLAN – Services not covered by your insurance plan are your responsibility and are to be paid in full at the time services are provided.

PRIVATE PAY PATIENT – If you have no insurance coverage, full payment is expected at the time of service.

SURGERY PATIENTS – Surgical procedures might require a pre-payment of deductible and co-insurance payments if applicable. You will be informed if this applies to your surgery. Surgery Date Change/Cancellation Fee is \$250.00 after your surgical consultation.

DELINQUENT ACCOUNTS – Statements are mailed out on a monthly basis. We request that your balance is paid off within 30 days. Past due accounts are subject to collection proceedings without further notice if unpaid after 90 days. In the event your account is turned over to collections, you are responsible for all associated collection costs and late fees.

RETURNED CHECKS – Returned checks are subject to a \$25.00 fee and all future payments need to be made by cash or a valid credit/debit card.

LABORATORY FEE – Laboratories bill separately for their services. Any Lab services that are not covered by your insurance will be your responsibility.

ADDRESS AND INSURANCE CHANGES – Please let us know if you have changes in your address, phone numbers, insurance, etc. so that your information is always current in our records.

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR - Patients under the age of 18 (minors) must be accompanied by a parent/legal guardian unless prior arrangements have been made. In the event that the accompanying adult is not the parent/legal guardian, Consent to Treat Form must be filled out. This can be found on our website. The person bringing in the child for medical treatment will be held responsible for payment at the time services are rendered.

DIVORCE/CUSTODY - Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at the time of service. Our office does require documentation from the court for all legal matters that relate to your child's care; *i.e.*, custody, medical decisions, medical record access, etc.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND I AGREE TO THE TERMS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN THE EVENT MY INSURANCE DENIES PAYMENT AFTER A CLAIM HAS BEEN SUBMITTED BY FOOT & ANKLE CENTER OF ARIZONA. I UNDERSTAND THAT MY INSURANCE IS AN ARRANGEMENT BETWEEN MYSELF AND MY INSURANCE COMPANY, AND THAT IT IS MY RESPONSIBILITY TO UNDERSTAND MY BENEFITS.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY:
