Ankle & Foot Specialists

FINANCIAL POLICY – ALL PATIENT PLEASE READ AND SIGN

Payment is due at time of service unless arrangements have been made in advance. If you are not prepared to pay for services rendered today, please notify the Office Manager/Billing Manager before you are seen by the doctor. We accept CASH, Debit Cards, Master Card, Visa, and Discover.

Please see additional information below and sign at the bottom of the page.

MEDICARE: We are a participating Medicare provider. Your fees will be based on that Medicare ALLOWS for our services. **You will pay your deductible if it is not met for the year, as well as your 20% co-insurance on any charges beyond the deductible amount if you do not have a secondary insurance.** You will also be asked to pay for any non-covered services. We will notify you ahead of time if the service to be performed is not covered by Medicare.

HMO/PPO INSURANCE COMPANIES: If you insurance company is an HMO or PPO (Preferred Provider Organization) with whom we are associated, you will be required to pay based upon your policy guidelines. **ESTIMATED CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES OR SUPPLIES ARE DUE AT THE TIME OF SERVICE.** If your policy requires a referral from your primary care physician, it is your responsibility to obtain this and provide us with a copy. If your insurance company denies payment due to no referral, you will be responsible for paying our full fees. **WE MUST BE ABLE TO VERIFY YOUR INSURANCE BY TELEPHONE PRIOR TO YOUR APPOINTMENT. IF WE ARE NOT ABLE TO DO SO, YOU WILL BE ASKED TO PAY OUR FULL FEES AT THE TIME OF SERVICE. IF COVERAGE IS LATER VERIFIED, WE WILL BE HAPPY TO REFUND YOU ANY OVERPAYMENT ONCE YOUR CLAIM HAS BEEN PROCESSED.**

Due to administrative constraints, unless specifically required at initial visit, any refund amount under $3.00 will be contributed to the Samaritan's Purse Ministry under the auspices of Franklin Graham.

CANCELLATION OF APPOINTMENTS/NO SHOW: If you are unable to keep your scheduled appointment, it is your responsibility to cancel your appointment by close of business the day before your appointment. No cancellations will be taken through our answering service after hours. **A $40.00 missed appointment/no show fee will be charged to you if the above policy is not followed.**

I hereby authorize payment directly to Dr. Thomas M. Reed of the surgical and medical benefits otherwise payable to me for his services. I understand that this does not release me from my personal responsibility for a payment of charges not paid by my insurance company. I also authorize any holder of medical information about me to release to Medicare or my insurance company and its agents and information needed to determine these benefits and process my insurance claim(s). This authorization shall be valid until revoked and a photocopy shall be valid as the original. **I ALSO AGREE TO PAY A $25.00 PER MONTH SEVICE CHARGE FOR ANY UNPAID BALANCE ON MY ACCOUNT 30 DAYS AFTER THE FIRST NOTICE FROM DR. REED'S OFFICE OF AMOUNT DUE BY THE PERSON RESPONSIBLE FOR THE ACCOUNT.**

It is your responsibility as the patient to notify Ankle and Foot Specialists if you have any changes in your physical or mailing address, your contact phone number, and/or your insurance. If you do not notify Ankle and Foot Specialists of this information and it becomes past the timely filing for your insurance you will be responsible for the full billed charges. It will then become your responsibility to file the claim yourself with your insurance company for reimbursement.

LEGAL ASSIGNMENTS OF BENEFITS

- The right of reimbursement for services rendered and cause of actions
- The right to collect or pursue and the right to enforce ERISA benefits
- The right to receive and applicable plan documents and any applicable remedies
- The right to sue on behalf of the patient
- Any other right permissible under state and federal laws
- The reason the benefits are being assigned, mainly for the provider who agrees to provide healthcare services
- The patient's and/or insured's signature

***Please sign that you have read and understand and accept our financial policy. This signature also authorizes payment of insurance benefits to the physician and the release of medical records to process your claim.**
***I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the notice.**

X_____ _____ _____

Signature of Patient or Responsible Party | Patient Name (print) | Date