NOTICE TO PATIENTS REGARDING INSURANCE

While we make every effort to assist you with your insurance questions and submissions, it is YOUR responsibility to verify your insurance coverage and to understand the extent of that coverage. Insurance companies are obligated to YOU, the insured, and not to our office. It is often difficult or impossible for us to get information regarding your insurance.
Together, we can make sure you receive the best care possible under your insurance company guidelines.

PATIENT FINANCIAL POLICY

- _____ (Initial) I understand that it is my responsibility to know and understand my insurance coverage.
- _____ (Initial) I understand that specialist co-pays (which may be different than my Primary Care Benefits), deductibles and co-insurance are due prior to services being rendered. I understand that this is a contractual agreement with my health plan to collect co-pays and deductibles at the time of service. I understand that once the claims have been adjudicated by my insurance company, there is a possibility that I may end up receiving a balance statement or a credit.
- _____ (Initial) I understand that all health plans are not the same and do not cover the same services. In the event that my health plan determines that a service is "not covered" or that I do not have authorization, I am responsible for charges for any services rendered. ***Patients are encouraged to contact their plans for clarification of benefits prior to services rendered***
- _____ (Initial) I understand that my insurance policy is a contract between myself and my insurance company. As a courtesy, Elite Foot and Ankle (EFA) will file my insurance claim for me. I agree to have my insurance company pay the doctor directly. If my insurance company does not pay Elite Foot and Ankle within a reasonable period, I will be responsible for payment.
- _____ (Initial) I understand that my insurance company may request information from me before processing a claim. It is my responsibility to comply with their request. Failure to comply may result in denial of my claim. I will be responsible for all charges incurred.
- _____ (Initial) I understand that I am responsible for all authorization/referrals needed to seek treatment in this office.
- _____ (Initial) I understand that it is my responsibility to inform EFA of ANY insurance changes and authorization/referral requirements at the time of check**.** In the event that EFA is not informed, I will be responsible for any charges denied.
- _____ (Initial) **There are NO refunds for supplies purchased in the office.** Unfortunately, not every supply prescribed works for all patients, but we strive to ensure we make every effort to have a satisfactory outcome.
- _____ (Initial) For Workers Compensation patients: we require a verified authorization from your insurance carrier prior to your initial visit. If your claim is denied you are responsible for payment in full.
- _____ (Initial) I understand that I will be billed for any amounts due by me (co-payments / co-insurance amounts / deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with **two (2) statements** for any balance due after insurance payment. I further that understand that if I have not made within 30 days of the second statement being mailed, that my account will be sent to collections.
- _____ (Initial) 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 my responsibility in addition to the balance due to Elite Foot and Ankle.
- _____ (Initial) I understand that if I present an insufficient funds check (NSF check) for payment on my account, I will be charged a **$35 NSF fee**. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- _____ (Initial) I understand that there is a **$20 fee** to complete disability paperwork. If additional disability forms require completion, I understand that an additional **$20 fee** (payable prior to compilation) is required.

Signature of Patient/ResponsibleParty:_____Date:____/____/____
Printed Name of Patient/Responsible Party:_____