Thank you for choosing our office as part of your health care team. In our effort to provide personalized care in the most efficient and economical manner possible, we are providing to all of our patients this copy of our Financial Policy. We ask that you take a few moments to read our financial policy and sign below

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

Your insurance policy is a contract that exist between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card.

New insurance companies are continually forming and existing insurance companies are rapidly changing. It is your responsibility to know the specifics of your policy (referral requirements, in and out of network physicians and facilities, etc.). Most policies now have deductibles, copayments, coinsurances, maximums and limitations (out of pocket expenses). If your annual out of pocket expenses have not been met, you will be required to pay a $125 deposit at the time of your visit. This will be applied to your account and a statement will be sent reflecting any additional monies owed following response from your insurance carrier.

We rely on you to inform us of all instances in effect and to notify the office immediately of any charges with your insurance. If you do not inform us of changes, you will be responsible for the services rendered. When multiple bodiless exist, it is the patient's responsibility to inform us which policy is the primary plan. If we are not provided ALL insurance information at the time of service, you will be responsible for paying Elite Foot And Ankle Specialists, LLC directly and then submitting for reimbursement for your insurance company.

I authorize treatment of the person named below and agree to pay for all fees and charges for me and my family show by statements promptly upon presentation thereof unless credit arrangements are agreed in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing whining thirty days of billing date. In event legal action should become necessary to collect unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees for collection or other and any such cost as the court determines proper.

It is agreed that payments will not be delayed or withheld because of any of the following reasons, including insurance review process or the receipt of other physician records/information or uncertain coverage determined by insurance carrier regarding such terms as "reasonable and customary fees" which are utilized by particular insurance carriers but which may not reflect fees or costs particular to this office. Fully understand usual and customary rates maybe different from charges for services rendered and I/we agree to pay fir any differences without regard to insurance determination of usual and customary or similar type coverage by my insurance carrier(s). In addition, no delay on payment will be withheld due to personal bankruptcy and or attorney advisement to not pay on the account nor any court action and not limited to worker's compensation cases, injuries, or for whatever reason discussed. I/we fully understand and assume all responsibility for payment of all medical services and ultimately understand it is my/our responsibility as the patient (or guarantor) to make sure that all fees and services rendered to be paid regardless of insurance coverage or any other third party payment arrangement.

It is agreed that all proceeds are assigned to this office where applicable but that this office assumes no responsibility for the collection thereof from either the insurance company assigning the benefits or the individual who may be in receipt thereof. No payment will are delayed as a result of pending claims or requests by any third party; attorney or insurance carrier for additional information regarding office documentation.

Any disagreement with any of the therms and authorization for treatment noted will be written on this form. If no such additional information is written, this agreement constitutes the complete financial arrangement and authorization for treatment and payment stated above. I fully understand all terms and conditions, and this has been fully explained to my satisfaction, and I have completely read this financial agreement and authorization for treatment.

DISCLOSURE/ AGREEMENT

I/we further agree to pay any additional collection agency fees, court cost and reasonable attorney fees should my accord be placed with our outside collection agency and/or law firm in order to collect the outstanding balance owed to us under this agreement. The collection agency fee wok be thirty-five (35) percent and will be based on the percentage of the balance of the debt being turned over to the collection agency at that time and a $35 dollar administrative fee will be added to the account balance.

Additionally, I/we agree to pay simple interest at the rate of 1 1/2% per month on the outstanding principle balance of my account starting from the final date of service or final statement date whichever is most current.

If the phone number(s) I/we am providing including my cell number(s), I/we consent to receiving auto dialed or rerecorded message calls from our outside collection agency/ and or law firm who may call when attempting to collect on any past due accounts our office has placed with them.

APPOINTMENT CHARGES

All charges are the responsibility of the patient. We will bill your insurance company, but any services not covered are the patient's responsibility. If you have no insurance, you are responsible for all services rendered. Co-pays will be college at the time of the appointment (as required by insurance companies). For new patient we will make every attempt to contact your insurance company to determine your office visit copayment, if any. Existing patients should notify us of any changes related to copayment amount right away

Cost can vary, depending on the type of insurance coverage you have and treatment for your particular condition(s). Cost/payment by your insurance company cannot be guaranteed by our staff. If you have any concerns, we advise you contact your insurance company.

If you miss an appointment, or cancel an appointment less than 24 hours of the appointment time, you may be assessed a $25 fee, as we have reserved that time slot just for you. Missed appointment fees are the responsibility of the patient

A $25 fee will be assessed on all returned checks

I have read and understand the Financial Policy of Elite Foot and Ankle specialist

Patient's Name (print):_____ Date of Birth_____

Patient's/Guardian's Signature:_____Today's Date:_____