ASSIGNMENT OF BENEFITS, RELEASE OF MEDICAL INFORMATION, PAYMENT AGREEMENT

I request and authorize that all insurance benefits of Medicare, major medical and/or private insurance be paid on my behalf to Professional Foot and Ankle Center. This is for all services furnished to me by Professional Foot and Ankle Center. “This assignment of Benefits” is to remain in effect until revoked by me in writing. A photocopy of this statement shall be considered as valid as the original. I further authorize Professional Foot and Ankle Center, to release any and all medical information necessary to process my claim and to secure payment.
I understand that I am responsible for any and all charges not covered by my insurance, including any deductible, co-insurance and/or co-payment.
Professional Foot and Ankle Center will make every effort to assist our patients in understanding the scope of their insurance benefits and the method of determining coverage. Nevertheless, it is ultimately your responsibility to understand your policy, its benefits and the obligations it places on you. It is not the responsibility of Professional Foot and Ankle Center to verify insurance coverage (this includes information as far as our physician in or out-of-network status) or determine which services are or are not covered. Additionally, it is your responsibility to insure that the following services, but not limited to; consultations, x-rays, orthotics, casting supplies, injections, foot and ankle braces, orthopedic boots and shoes, diabetic shoes and inserts, surgical procedures, laboratory tests, etc., are covered by your insurance. Therefore, if your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly.

FINANCIAL POLICY

Payment in full is required at the time professional services are rendered unless other arrangements are made in advance. Payment of deductibles, co-pays, and your unpaid insurance portion is required at the time professional services are rendered. If you have medical insurance, your insurance will be billed. You are responsible for the unpaid portion after 30 days.

MEDICARE
If you have Medicare, you will be billed only for the unpaid portion of the Medicare allowed services. Your co-insurance will be billed as a courtesy. Professional Foot and Ankle Center is a participating Medicare provider. Federal law requires all patients be billed for the unpaid 20% of their Medicare-covered services and for their annual deductible.

HMO
Please note that the authorization is for requested services only and the expiration date is the last date on which the authorization can be used. After such date, the authorization will no longer be valid. All payments are subject to the member’s updated eligibility, covered benefits, medical policy and reimbursement schedules. Services rendered that exceed benefit limitations, even if authorized, will be the member’s financial responsibility. The authorization does not confirm eligibility. Payment of services is based on the member’s participation in the Health Plan program at the time of the visit. Additionally, HealthCare Partners processes and pays claims according to CMS guidelines. This includes the use of the National Correct Coding Initiative edits which promotes correct coding methodologies and controls the improper coding that leads to inappropriate compensation. If additional care or visits are required, they must be authorized prior to care being rendered.

ALL PATIENTS
I agree to allow Professional Foot and Ankle Center to accept third-party payments from my insurance company; however, I agree to take financial responsibility for co-payments, deductibles, and any amounts not covered by my insurance company.

Please remember that insurance is considered a method of paying for health care costs. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. By your signature below, you hereby agree that it is your responsibility to pay any deductible, co-insurance, co-payment or any other allowed amount not paid for by insurance. Our office is not responsible for inaccurate or incomplete information supplied by you or your insurance company, and you accept full responsibility for payment should you or the insurer supply us with wrong, incomplete, or false information. In order to control our cost of billing, office co-payments, co-insurance and deductibles are due on the day you are seen.

MISSED APPOINTMENTS
I understand that appointments are pre-arranged and it is my responsibility to keep the appointment or cancel with a minimum of ***24 hour*** notice. I understand that I may be billed ***$50.00*** for any missed appointments.

I have read and understand the above information and accept full responsibility if my insurance does not pay for services rendered, as well as any collection and/or legal costs incurred due to non-payment.

_____ _____
Signature of patient or Responsible party **Date**

_____
Please print patient Name