Family Foot and Ankle Specialists
Dr. Steven Brancheau, Dr. David Minchey, Dr. Ashley Diamond, Dr. Paul Brancheau

Statement of Patient Financial Responsibility/Consent for Treatment

Patient Name: _____ DOB: _____

Family Foot and Ankle Specialists appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full within 60 days. We accept payments by cash, check, Visa, MasterCard, American Express and Care Credit.

You are responsible for presenting correct insurance information at the time of service. We will need to obtain a current copy of your insurance card and a state issued photo ID. Most insurance companies have time limits for claims to be filed. Failure to present correct insurance information may delay your claim causing it to be denied. You will be responsible for full payment if this occurs.

Patient statements are mailed monthly as a courtesy. You are responsible for any amount not covered by your insurance even in the event that you do not receive your statement. Please review your explanation of benefits from your insurance company explaining the amount due for each date of service.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. If you do not call to cancel/reschedule your appointment within the 24 hour time frame, a $35.00 fee will be charged to your account and must be paid in full before future appointments are made.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. You will be notified in writing, via certified mail, if you are discharged from care.

_____initial

Accounts not satisfied within 90 days from the date of service or 60 days from the date of insurance payment may be turned over to a third-party collection agency.

____initial

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

____initial

Medicare

I understand that all services provided at Family foot and Ankle Specialists may not be a covered Medicare benefit. Please refer to your Medicare handbook for a list of covered podiatry services. I agree to be fully responsible for any amounts not covered by Medicare. You will be responsible for the Medicare deductible (183.00) and the 20% not covered by Medicare at the time of service unless you have a secondary insurance that covers those items.

____initial

Medicaid

We will file Medicaid provided eligibility is current on the date of service. We will not file claims for patients who receive Medicaid retroactively.

____initial

Worker's Compensation

We do accept work comp claims provided authorization has been received from the insurance company. Please notify the front desk prior to treatment if this is an on the job injury.

____initial

Auto Accidents/Homeowner's Claims/Business Claims/Third Party Liability

WE DO NOT accept any of the above third-party insurances. You will be considered a self-pay patient and we will provide documentation necessary for you to submit for reimbursement.

____initial

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Family Foot and Ankle Specialists. I agree to pay Family Foot and Ankle Specialists for the full and entire amount for treatment rendered to me or to the above-named patient at each visit.

____initial

Over the Counter Supply Items

Many items dispensed at the time of service are considered over the counter supply items and are not covered by your insurance company. Please be prepared to pay for these at the time of service. ****PLEASE BE ADVISED-ONCE A SUPPLY ITEM IS RECEIVED IT CANNOT BE RETURNED UNLESS THERE IS A MANUFACTURER DEFECT WITHIN 30 DAYS OF RECEIPT. (example: straps torn, stitching unraveling, or product breaks)

____initial

FMLA/Disability Forms/Medical Records

There is a $25.00 charge for the completion of FMLA and disability forms. Copies of medical records require administrative time and office materials. The fee for this is $ 25.00 for the initial 20 pages and .50 for each additional page. The fee for copies of x-rays is $7.00. Postage will be billed at the actual rate of any postage used. These fees are due at the time of completion. Request for medical records must be made in writing and will be released within 15 business days of receipt of the request.

____initial

*******Referrals*******

You are responsible for obtaining any referrals required by your insurance company. We will assist in the process by sending records to your primary care physician. You will be financially responsible for all visits for which a referral was not obtained.

____initial

Disclosure of Financial Interest

Family Foot and Ankle would like to make you aware that all three physicians have financial interest in the Rockwall Surgery Center. You have the right to request any procedure to be performed at the facility of your choice as medically necessary.

_____initial

Assignment of Benefits

_____I authorize the Doctor to release all information necessary to secure the payment of benefits.
_____ I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered.
_____I authorize the use of this signature on all insurance submissions.

Notice of Privacy Practices

I have read and understand the notice of Privacy Practices provided to me by Family Foot and Ankle Specialists. I understand I have the right to request a copy of this document. I understand that pursuant to Texas law, my medical condition is confidential. In order for my physician and staff to discuss my medical condition with my family members or friends, I understand that I must give written authorization. Therefore, I _____ hereby give the staff at Family Foot and Ankle specialists the authority to discuss my medical condition with the following individuals. If none, state none.

1._____ 2. _____ 3. _____

Any change in the designation must be in writing and may be changed at any time.

Patient/Guarantor Signature _____ Date _____

I have read and understand the above statement of financial responsibility, and I agree to the terms described. All of my questions have been answered to my satisfaction.

Patient/Guarantor Signature _____ Date _____

High standards of professional service require the doctor to devote to each patient ample time to consider his/her individual problem. For this reason, delays may occur in our carefully planned appointment schedule.

Family Foot and Ankle Specialists: _____ Date: _____