NORTHWEST FOOT AND ANKLE INSTITUTE PLLC
2075 BARKLEY BLVD, SUITE 220
BELLINGHAM WA 98226
PHONE: (360) 933 – 4813
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# GENERAL AND FINANCIAL POLICY

***Welcome to Northwest Foot and Ankle Institute. Thank you for choosing our medical service!***
Please review the following policies for our facility. Occasional updates to these policies may occur.

**LATE APPOINTMENTS & CANCELLATIONS:**
If you arrive more than 15 minutes past your appointment time, we reserve the right to reschedule your appointment to another date/time. If you need to cancel or reschedule your appointment, please provide a 24-hour notice. Failure to comply may result in a $25 charge. Repeated failure to keep scheduled appointments may result in a dismissal from our medical services.

**MEDICAL RECORDS REQUESTS:**
There will be a minimum of $10 handling and preparation fee for requests for medical records from any party other than the patient's health insurance company and other medical professionals. Any record more than 5 pages will be charged with additional $2 dollars per additional page. This fee must be paid prior to the release of the records. An additional $10 will be charged for copies of x-ray in a photo format. A medical record release form is required to be signed before records can be released.

**AFTER-HOURS PHONE CALLS:**
For any concerns and questions, please leave a message at our office, (360) 933 – 4813.
For any immediate post-surgical questions, please contact the doctor directly at the number provided to you during the pre-operation consultation.

**CONSENT FOR TREATMENT:**
We strive to provide you with the highest standard of medical care. When our doctors are treating you, you are consenting to the treatment or procedure provided by Northwest Foot and Ankle Institute PLLC and its employees. You are authorizing the physical health care services deemed necessary or advisable by our doctors. Possible benefits, complications, risks will be discussed with you. You are consenting to follow the post treatment or procedure protocols advised to you by our physicians. Please ask any questions you may have to your full satisfaction. No guarantee or assurance will be made as to the therapeutic results that may be achieved. You have the right to refuse any treatment at any given time, and you must notify the doctor, if you wish to decline or refuse any treatment. Your opinion is important to us.

**EMERGENCIES:**
For any life-threatening emergency, please call 911 or go directly to the local emergency room.
During clinic hours, urgent medical issues will be seen and treated promptly. This may mean a disruption in your scheduled appointment. Emergent circumstances will require an immediate attention.

**BILLING AND INSURANCE:**
We are contracted with various insurance companies and will bill them directly. Any remaining balance will be billed to you. Please bring your insurance card to each visit to ensure we bill your insurance correctly. If you have coverage through a non-contracted insurance plan, we will provide you with a coded bill to submit to your insurance company. It is your responsibility to follow up with your insurance company and pay the bill in a timely manner. The insurance companies that we are contracted with may change from time to time. If you are considering a new insurance plan, please call our clinic to check if we are contracted with that plan. If you are injured in a motor vehicle accident and have personal injury protection through auto insurance, your healthcare insurance will not cover the cost of the treatment. You are responsible for the charges at the time of the visit. When a patient turns 18 years old, they become the guarantors of their account. They will be asked to review their own financial agreements the first time they a have a visit after turning 18.

**FINANCIAL INTEREST STATEMENT:**

Northwest Foot and Ankle Institute PLLC is a family owned company that has a financial interest in the ancillary services provided in our clinic, such as diagnostic services, or specialty care. You always have the option to use an alternate facility for services ordered. You will not be treated differently if you choose to do so. We will try our best to provide you with a list of appropriate alternative facilities if you want to received services elsewhere.

**PAYMENT AND FEES:**

We request payment at time of service for co-pays, coinsurance, and private pay. Private pay patients receive a discount when fees are paid on the day of the service. Co-pays not paid at the time of your visit may be subject to an additional charge to your account. If you are having financial difficulty, please contact our office for establishing a payment plan. Repeated failure to pay may result in dismissal from Northwest Foot and Ankle Institute PLLC and assignment of your account to a collection agency in the event of non-payment. A rebilling fee / finance charge may be applied to any overdue balance, authorized by Washington State Law.

***Please make checks payable to: "Northwest Foot and Ankle Institute PLLC".*** If your check is returned for non-sufficient funds, we will add a service charge to your account. If that happens, you will be asked to pay the amount of the check plus the service charge $30 in cash within 10 day. If your account has not been paid in full by then, it may be referred for collection action.

Some insurance plans do not cover certain procedures, such as certain treatment injections, custom orthosis, and certain cosmetic procedures. In such cases, you will be asked to sign a waiver agreeing to pay for the visit at the time of service. Please call your insurance company to determine coverage for a procedure that is being considered.

**MEDICARE:** I understand my medical provider agrees to accept the Medicare allowed charge as the full charge, and I am only responsible for the deductible, co-insurance and non-covered services.

**HMO Policies:** I understand that it is my responsibility to obtain referrals from my primary care physician. If I do not supply a referral for any appointment where on is required, I understand that I will be responsible for payment in full at the time of service.

**ACKNOWLEDGEMENT**

I fully read and understand the information and authorization noted on this form. I authorize my insurance benefits be paid directly to the health care provider. **I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collection of any amounts owed on this visit or future visits, I agree to pay for all costs, including attorney fees.** I authorize the health care provider or insurance company to release any information required for the claims associated with the clinic visit. I hereby authorize the physician to conduct examinations, perform procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I also understand I may revoke the privilege listed in this form at any times by submitting my request in writing to this office.

**Patient Name:** _____ **Date of Birth:** _____

Print Name

**Signature:**_____ **Date:** _____

**Parent/Authorized Representative** *(if applicable)*: _____

Print Name