ANKLE AND FOOT CLINIC FINANCIAL AGREEMENT

1. Financial Agreement: Patient responsibility

We are committed to providing you with the best possible care. If you have medical insurance, we will work to the best of our ability to help you receive the maximum allowable benefits. To achieve these goals, we need your assistance, and your understanding of our payment policy. We will be happy to help you process your insurance claim form for your reimbursement.

Your co-payment will be due at the time of service. Failure to pay this at the time of service will result in a $5 billing and processing fee. **Our office does not finance balances.** We accept cash, check, Visa, or MasterCard. Care Credit is also offered with shorter term financing offered at no or minimal interest. If you are interested in Care Credit and are not already a member, please ask our receptionist for additional information. There is an additional $20 charge for insufficient funds on returned checks. When your account has balances due over 30 days, a 1.5% monthly finance charge will be assessed, unless other arrangements have been made. A balance that is older than 90 days will be referred to our collections legal department, unless other arrangements have been made. You will be responsible for all fees associated with collections including attorney fees and court costs.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. We are contracted with most insurance companies and will make contractual adjustments per our contract with them. Please ask the receptionist if you don't know if we are contracted with your insurance company.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Non covered services are the patient's responsibility.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. **We are here to help you.**

2. Insurance Agreement: Direct Payment Assignment & Information Release

- I hereby name the Doctor and/or Medical Practice given below, hereafter referred to as DOCTOR, as my assignee. I instruct my health care benefits plan administrator, i.e.; insurance company, HMO, employer or government benefits provider including Medicare, hereafter referred to as the PLAN, to pay the DOCTOR directly for all professional and medical services provided by the DOCTOR, through the means of electronic funds transfer(s) (EFT) or by check(s) made payable to and mailed to the DOCTOR:

  Ankle and Foot Clinic of Idaho
  Andrew L. McCall, DPM
  2920 Cortez Ave
  Idaho Falls, ID 83404

  If my current policy prohibits direct payment to doctors, then I hereby instruct and direct the PLAN to make out all checks payable to me and mail the payments to me in care of the DOCTOR as given directly above.

- **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**
- A photocopy of this agreement, or an electronic facsimile thereof, shall be considered as effective as the original.
- I understand that additional information about me will be needed by the DOCTOR and PLAN to determine and communicate what services or benefits are covered by the PLAN, and to submit or process a claim for payment on services rendered and for the DOCTOR to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I give to the DOCTOR, the PLAN, the Health Care Financing Administration including Medicare, their agents, and/or any other holder of information about me, authorization to release and/or exchange medical, billing, and collection information.

____________________________________ ____________
Signature of the Policyholder Date

____________________________________ ____________
Signature of Patient (If other than the policyholder) Date