

**FOOT & ANKLE ASSOCIATES, LTD.**  
**FINANCIAL POLICY**

Thank you for choosing us as your family's health care provider. We are committed to the success of your treatment. Please understand that the payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we request that you read, agree to, and sign prior to any treatment. You must also fill out our **Patient Information** form completely.

**Contracted insurance plans** require Foot & Ankle Associates, Ltd. to collect your co-payment at the time of service.

**HMO insurance** requires a valid referral for every visit to this office. You are responsible for obtaining and being aware of the extent of treatment of that referral. If there is no valid referral, you have not complied with the terms of your insurance and you will be responsible for that visit.

**Workers' Compensation Claims:** If you wish us to file with your Workers' Compensation carrier, it is necessary that you provide the name of the carrier, address, phone number, claim number, and a contact person. You must also provide information regarding your regular health insurance carrier, so that if your claim is denied, we will be able to file with them.

**Method of payment:** We will be happy to assist you in filing an insurance claim for reimbursement. However, you must understand that **your policy is an agreement between you and your insurance company. We may not be a part of that contract. Our primary relationship is with you—not your insurance company.**

Not all services are a covered benefit in all insurance contracts.

If the insurance company or Workers' Compensation does not pay your bill in full within 90 days, you will be responsible for any and all charges. If you fail to respond, your account will be turned over to an outside collection agency. Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary. We understand that things do happen and financial problems may affect timely payment of your bill. As always, we will do what we can to help you. All we ask is that you contact us as soon as possible to make arrangements.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and the opportunity to serve you.

**ASSIGNMENT AND RELEASE:** I hereby authorize payment to be made directly to Foot & Ankle Associates, Ltd. I fully understand that I am the responsible party for all charges incurred by me or my dependents at the above facility. For purposes of processing my claim, I authorize the release of information which may include, but not be limited to, name, address, phone number, social security number, employer, and employer phone number. If legal action becomes necessary to enforce payment, I agree to pay all reasonable fees.

Responsible Party Signature: \_\_\_\_\_

Responsible Party Name (please print): \_\_\_\_\_

Date Signed: \_\_\_\_\_