# Family Foot & Ankle Specialists

## Statement of Patient Financial Responsibility & Consent for Treatment

Patient Name: _____ DOB: _____

Family Foot & Ankle Specialists appreciate the confidence you have shown in choosing us to provide for your healthcare 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.

### 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 patient to pay at EACH VISIT. Thank you for your cooperation in this matter.

### Medicare

I understand all services provided at Family Foot & Ankle Specialists may not be covered by Medicare benefits. 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 financially responsible for the Medicare deductible and the 20% not covered by Medicare at the time of service, unless you have secondary insurance that covers those items.

### 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.

### Worker's Compensation

We do accept workers compensation 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.

### 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 reimbursement.

### Self-Pay

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

## Over the Counter Supply Items

Many items dispensed at the time of service are considered over the county supply items and are not covered by your insurance company. Please be prepared to pay for these at the time of service. If you have any questions about the pricing of your needed items, please check with your physician or medical assistant and they will be happy to review the cost with you. **Please be advised** *once a supply item is received it cannot be returned unless there is a manufacturer defect and within 30 days of receipt (i.e. straps torn, stitching unraveling or product breaks).*

## FMLA / Disability Forms / Medical Records / X-ray copies

There is a $25.00 charge for the completion of FMLA paperwork, disability forms, or copies of medical records. Copies of medical records require a request made in writing and will be released within 15 days of the receipt of the request. The fee for copies of x-rays is $10. Postage will be billed for the actual rate of postage used, if it is necessary to mail the records.

## 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.

## Notice of Privacy Practices

I have read and understand the notice of Privacy Practices provided me by Family Foot & 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. 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 of Family Foot & 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 my questions have been answered to my satisfaction.

Patient/Guarantor Signature _____ Date: _____

*High standards of professional service require our physicians to devote time to each patient to consider his/her individual problem. For this reason, delays may occur in our carefully planned appointment schedule. Please be understanding of this and ask the front desk if you have any questions.*