Patient Name_____DOB_____

Patient Financial Agreement

If we are not a contracted provider with your insurance, this office will NOT submit a claim. You will be responsible in full for all charges at the time of service. We accept cash, check, Visa, MasterCard, Discover, or American Express. We can provide you with a detailed receipt if you would like to submit a claim to your insurer for possible reimbursement. KNOW YOUR OUT-OF-NETWORK BENEFITS. We will not get involved in any dispute between you and your insurance company.

All accounts with an unpaid balance will be assessed a **$5.00 fee** per billing statement until the balance is paid in full. A **$25.00 surcharge** added to the account for any returned checks. If the account becomes assigned to a collection agency, you agree to pay all costs of collection, including agency fees, court costs, and attorney fees.

A patient may return any defective or ill-fitting durable medical good or product dispensed by this office within **ten (10) days** from the date of service. The issue may be remedied by replacing the product, adjusting or modifying the product, or accepting the product for a return with a credit issued for the full amount. Custom-made or special order items are NOT returnable.

We do our best to keep on schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive past your scheduled appointment time, we reserve the right to reschedule your appointment. We reserve the right to charge a **$60.00 "no-show" fee** to your account for each missed scheduled appointment if you do not call to cancel or reschedule in advance.

Medicare Assignment and Release

Because we are contracted providers with Medicare, this office will file a claim on your behalf. In order to do so, we will require a copy of your insurance card(s) and photo identification for our records. **Without an insurance card and proper identification, we will be unable to file your claim**, and you will be responsible for the full amount of all charges accrued. This practice will not file a claim to any supplemental insurance(s) to Medicare unless it is an e-crossover from Medicare.

The ultimate responsibility for understanding your insurance benefits rests with you. **You are financially responsible for payment of all deductibles, co-insurance, and all non-covered services or supplies not paid by Medicare.**

Please be advised that certain items and services necessary to provide you with optimum foot care are generally NOT covered by Medicare. ***Non-covered services include:***

- Routine foot care, including the cutting or removal of corns and calluses, and the trimming, cutting, clipping, or debriding of toenails
- Evaluation and treatment of flat feet or bunions, including the prescription of supportive devices (orthotics)
- Certain supplies, including supportive devices (insoles), splints, paddings, or medicated creams and solutions dispensed by this office

I, the undersigned, assign directly to Albemarle Family Foot & Ankle, PLLC. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize any holder of medical information about me to release all information needed in order to secure the payment of benefits. **I understand that I am financially responsible for all charges whether or not paid by my insurance**. I authorize use of this signature on all insurance submissions. This authorization is valid for current and subsequent treatment unless I submit a written revocation.

Patient (Guarantor) Signature_____Date_____