



# A M E R I C A N Foot & Ankle Specialists

## Our Financial Policy

We try to provide the highest quality of care to our patients while being considerate of the cost of the care. To help us achieve this and to minimize our administrative costs, we ask that you pay your bill at the time of your visit.

### Your Insurance

We will bill those plans with which we have a signed contract. You will be responsible for all co-pay and deductible amounts at the time of your visit. We will provide you with a form to submit to your insurance company, if you are on a non-contracted plan. You are responsible, however, for paying the entire bill at the time of service. You will then receive reimbursement directly from your insurance company.

- I fully understand that I am financially responsible for all co-pays and deductibles required by my insurance plan, to be paid at the time of my visit.
- I understand that I am responsible for any services that my plan determines to be "non-covered".
- I understand that payment is expected at the end of each visit unless other arrangements have been made.
- I understand that if the doctors are not participants in my insurance plan, I will be responsible for full payment on the day of service and that **I will be responsible to file** my claim with my insurance plan.
- I understand that medical insurance may not pay my entire bill and that I will receive a bill for the portion of the fees that are my responsibility.
- I understand that interest may be charged on any unpaid balance at 1.5% per month.
- I understand that I will be billed \$20.00 for all checks that are returned by the bank.
- I understand that the office is not able to verify insurance benefits for every patient, and that I have the ultimate responsibility for my insurance coverage.
- I understand that I am responsible for understanding my plan's benefits and for selecting a physician on the plan.
- I agree to pay all amounts owed and all expenses incurred in collecting any unpaid balance.
- I understand that my insurance or I will be billed \$50 for appointments that are considered No Show by AF&AS.
- I authorize release of medical information to my insurance company. (If I do not authorize release, then I understand that payment will likely be denied or delayed by my insurance company. In this circumstance, I understand that I will be responsible for my bill).

### Minor Patients

For all services rendered to minor patients (under the age of 18), we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

### Referrals

If your insurance plan requires that we obtain a referral for you to seek medical attention with another doctor, you must notify our office seven (7) days in advance of your appointment. Otherwise, we cannot guarantee that you will have this referral. In that event, your visit may be paid "out-of-network", if available, according to the terms of your insurance policy.

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Patient Name

Signature of Patient or Responsible Party

Date