Name, address & Phone Number of Relative or Friend NOT living with you in case of an emergency: (*Information is REQUIRED by Doctor*)

Name:
Address:
City, State
Zip code:
Contact's Phone#:
Relationship to Patient:

Today I will be paying by: ☐ Cash ☐ Credit Card Check

Read the following Payment Policy CAREFULLY then SIGN and DATE below

1) Authorization to Release Medical Information:
I authorize release of medical information necessary to process this (these) insurance claim(s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims:

1) A photocopy or other facsimile reproduction of this authorization, or
2) Use of a computer to indicate my signature is on file at the Clinic, and/or
3) Use of a computer to electronically transmit my claim for Processing.

2 Authorization to Assign Medical Benefits To Clinic:
I certify that Information provided relative to injury, illness, and Insurance coverage is both true and correct. **I will notify the Clinic of any changes to the information supplied**. I authorize Payment of insurance benefits or proceeds from any liability claim Or legal/court settlement to be assigned to the physician of this Clinic to the extent that their charges are paid in full.

3 Acknowledgement of Insurance Limitations:
Most Insurance carriers require a written referral from a primary care physician in advance of Services (office visits, surgery, and diagnostic Tests – MRI). **Patient's are responsible for:** (1) Obtaining physician Referrals and (2) contacting their insurance carrier to Verify benefits in advance of service. Patient's are also responsible for non-covered services, deductibles, co-Insurance, and any penalties imposed by their insurance Company on our doctor for seeing patients out of Network. **Copayments and deductibles are due at the time of service.**

4 Acknowledgement of Payment Responsibility:
Payment for medical services is between the Clinic (doctor) and the patient. Payment is due in full according to the terms of this Clinics financial policy.
Therefore, I understand that this Clinic cannot accept the responsibility for collecting or negotiating settlement on any disputed, (1) health insurance claim (2) accidental injury/illness liability Claim, (4) claim where patient is/will be represented by an attorney, and/or (5) claim to be settled in a court of law.

Signature of Patient or Authorized Representative:	**Date:**
X ________________________________	

ADVANCED FOOT AND ANKLE CENTER

Payment Policy

Thank you for choosing Advanced Foot and Ankle Center as your foot care provider. We are committed to providing you with quality and affordable health care.

Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

As of January 1, 2010 the office of Advanced Foot & Ankle Center is accepting checks. However, we now charge a return check fee in the amount of $50.00. Out of town checks will not be accepted.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of you contact with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non refundable if the proper referral is not obtained by then.

4. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

5. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A re-billing charge of $10.00 per month will accrue on all accounts over 60 days past due. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

7. Missed Appointments. Our policy is to charge $25.00 for missed appointments not canceled within a reasonable amount of time (24 hours) or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Our fees are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

____ ________________________

Signature of Patient or Responsible Party Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medial records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak to the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of April 14, 2003.

Patient signature: ____ Date: _____________

List family/friends that we may discuss your medical/financial matters with:____________

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Advanced Foot and Ankle Center
5531 Virginia Parkway #100
McKinney, TX 75071

Laboratory Services

Unless you instruct us otherwise, any specimens taken will be sent to **Bako Pathology Services**. Bako accepts all major insurance plans. Please be advised since we do send all specimens to an outside lab we do not charge for the actual test. There is a possibility you will receive a bill from Bako if the services are not covered by your insurance.

When you are sent to an outside lab for blood draw, we will send you to either **Lab Corp** or **Quest**. Again, since we do not charge for the actual test there is a possibility you could receive a bill from **Lab Corp** or **Quest** if the services are not covered by your insurance.

We will make every effort to notify you of your results whether they are normal or abnormal. Please allow 5-7 business days for results. If you have not received notification of your results within a week, please call the office.

I have read this document and understand the policies and my financial responsibility.

Patient's Name (print) ____

Patient Signature ____

Date ____