Authorizations

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have complete the form to the best of my ability. I understand that is is my responsibility to inform Foot And Leg Health Care any changes to my medical status. I hereby consent and authorize Foot And Health Care Center and staff to perform any service deem appropriate by the attending physician to make thorough diagnosis. I also authorize Foot And Leg Health Care Center to perform any procedures, forms of treament, medication, and therapy in connection with my diagnosis and treatment plan.

Print Patient Name:_____ Date:_____

Signature:_____
Parent or Authorized Rep (if applicable)

I am ultimately responsible for payment of charges for the services I receive from this practice including those covered by my insurance. Some immediate payment may be expected at the time of service. This may include co-pay and additional payment if my deductible is not yet satisfied. I understand if a surgical procedure is preformed in office that I have a one time $45 surgical fee towards my visit. I understand that this payment is due the day of service and this practice may deny service for failure to pay copay,deductible etc at the time of service. I understand the fee for a returned check is $35.00 and this practice will no longer be able to accept a check as a form of payment.

Print Patient Name:_____ Date:_____

Signature:_____
Parent or Authorized Rep (if applicable)

Insurance is a contract between you and your insurance company. We will bill your primary insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary, As well as, any change of insurance information. Failure to provide complete insurance information may result in a patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility and benefits. With your contract with your insurance company you agree to pay any portion of charges not covered by insurance, including but not limited to those charges about the usual and customary allowance. If you are out of network, or a cash payer you are responsible for the payment and agree to move forward with the payment to us immediately.

Certain health insurances require you to obtain a referral or prior authorization from your primary care physician before visiting a specialist. If you insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain this information may result in a lower or no payment from your insurance company and the balance will be your responsibility. Rescheduling your appointment may be necessary if not obtained.

Print Patient Name:_____ Date:_____

Signature:_____
Parent or Authorized Rep (if applicable)

Completion of forms (e.g. Disability or Family Medical Leave, Handicap form) and copies of medical records are not a billable reimbursement by insurance carriers. Therefore you are responsible for the fee related to the completion of this documents. The fee is $45 for FML/disability. Handicap fee is $25 and other forms needed to be filled is $10 per page. This payment is due when the forms are presented for completion.

Print Patient Name:_____ Date:_____

Signature:_____

Parent or Authorized rep (if applicable)