

Family Foot & Ankle Center, P. A.

Patient Name \_\_\_\_\_

1. As the patient, you are responsible for full payment of your bill. However, as a courtesy, we will bill your health insurance carrier if all the necessary information is obtained on the date of service. If you do not have your insurance card it will be assumed that you do not have insurance and you will be responsible for your charges at this time.

2. If you are covered by more than one (1) insurance company, we will also file the second carrier as a courtesy as long as you have your insurance card so we can obtain the information needed for the file.

**EXCEPTION:** Medicare may not cross over to out of state Blue Cross Blue Shield. As a result we will courtesy file but we will collect the twenty percent (20%) for any Medicare claims and will reimburse if out of state Blue Cross pays.

3. If your deductible has not been met, we require payment at the time of service up to your deductible and then will collect your twenty percent (20%) or your percentage thereafter.

4. If your insurance company has not remitted payment forty-five (45) days after we have billed them, you will be notified. At that time, you will be asked to remit full payment on your account.

The patient is responsible for payment of the total charges shown on the bill. As a service to our patients, we file for insurance with your insurance carrier. We can not, however, guarantee payment of any of the charges shown on this bill. Payments will be shown on your account only after they are actually received by this office. The estimated amount due from the patient is based on a preliminary review of the patient's insurance coverage and is due from the patient or responsible party upon receipt of the bill. Overpayment will be refunded by check to the party due the overpayment.

**Failure to give a 24 hour notice of cancellation will result in a \$25.00 No Show Fee.**

If you wish to inquire as to why your insurance company has not paid, we suggest you do the following:

- Contact your insurance company at the number listed on your insurance card.
- Advise your insurance company that because of non-payment of your claim, payment is being requested in full.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_