Town Square Family Foot Care – 501 12th Avenue, Suite 203 – Coralville, IA 52241

FINANCIAL AGREEMENT / AUTHORIZATIONS

Thank you for choosing our office as your foot care provider. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. Please read and sign this FINANCIAL AGREEMENT.

INSURANCE

Patients must present their insurance card. **Copayments are due on the day of service**. Your insurance policy is a contract between you and your insurance company. Please be aware that all charges are your responsibility whether or not your insurance company pays your claims.

By signing this policy, you agree to permit us to electronically submit insurance claims and accept payment directly for services rendered to you. We will keep track of necessary documentation, referrals, and pre-certifications you will need to be treated in this office. However, as our patient, you are ultimately responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes and authorization requirements, referrals, and pre-certifications.

If the insurance company does not pay within 60 days from the date of service, the patient or guardian seeking care for a minor, will be responsible for payment of services. Patient must verify our doctors are "in-network" or be subject to out-of-network rates. Not all services are a "covered" benefit in all insurance policies. In the event your health plan determines a service to be "not covered/pre-existing", or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges for services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services being rendered.

PAYMENT FOR SERVICES

We accept cash, checks, VISA, and MasterCard. We will send you a billing statement for coinsurance, deductible, and non-covered amounts after insurance has processed your claims. We expect payment in full within 30 days of your statement.

Where minors are concerned, the parent or guardian that signs this policy is the only party that will be held financially responsible. If the patient is not a minor, then the patient is the only person held financially responsible.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing.

PAST DUE accounts will be assessed a finance charge of 1.5% per month, and collections proceedings and/or legal action will be taken. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance owed to this office. There is a $20 charge for returned checks. Accounts no longer maintaining a financial "good faith" status will result in you and your immediate family members being discharged from this office. If this occurs, you will receive a certified letter and have 30 days to find alternate podiatric care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

ONLY UNWORN and NON-custom items are returnable within 3 days of receipt. Custom items are not returnable.
Durable Medical Equipment includes splints, braces, cam walkers, crutches, etc. Certain insurances will not cover the cost of these items. Your benefits are determined by your policy. You are responsible for any outstanding balance. Federal regulations prohibit the return and resale of this equipment.

AUTHORIZATIONS AND ASSIGNMENT

I hereby assign all medical insurance benefits directly to Town Square Family Foot Care for payment of any services rendered. I agree to pay the amount charged by Town Square Family Foot Care. I have read and understand this Financial Agreement. I authorize the use of this signature for all insurance submissions. I authorize release of medical records necessary to process my health insurance claims. I understand that in the event my insurance company does not pay for services I received, I will be financially responsible for payment.

I acknowledge that I was provided a copy of the Town Square Family Foot Care Notice of Privacy Practices.

I permit a copy of this authorization to be used in place of the original.

I hereby give authorization for treatment. Patient's Name, if minor: _____

Signed: _____ Date: _____
(Patient Signature or Financially Responsible Party/Parent/Guardian, if minor)

Printed Name: _____ Relationship to Patient: _____

Effective Date: February 18, 2014