FOOT AND ANKLE MANAGEMENT GROUP

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FINANCIAL POLICY

I am aware that I am ultimately responsible for payment of the services I receive regardless of insurance, regardless of outcome. I understand that additional charges will be added to my account for returned checks and rebilling of statements for accounts left delinquent. I understand that delinquent accounts may be referred to a collection agency and that I will be responsible for the collection costs. I may also be responsible for attorney fees and court costs.

COLLECTION OF ALL APLLICABLE COPAYS, CO-INSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME OF SERVICE.

SIGNATURE _____ **DATE** _____

INSURANCE/MEDICAL RECORDS RELEASE AND PAYMENTS

I authorize The Foot and Ankle Management Group, to release any and all medical records to my insurance company(s), and to my referring family physician as deemed necessary. I authorize payment of medical insurance benefits either to The Foot and Ankle Management Group or to the party accepting assignment. This authorization shall be valid for services and treatment received today and all future visits/treatment.

SIGNATURE _____ **DATE** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the notice of privacy practices and that I have read (or had the opportunity to read if I so chose) and I understand the notice.

PRINT NAME_____**DATE** _____

SIGNATURE _____ **DATE** _____