Clear Form

Marvel Foot & Ankle Centers

PATIENT FINANCIAL AGREEMENT

We strive to maintain a strong physician-patient relationship. Sharing our Financial Policy in advance allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.

Health Insurance

- **WE DO NOT PARTICIPATE WITH ANY MARKET PLACE PLANS.**
  Deductibles, copays, and coins payments are your responsibility and are due at the time of service.

  DEDUCTIBLE (an amount you must pay first out of your own pocket each year before insurance begins paying for any services),
  COPAYMENT (an amount you must pay at each doctor's visit that is due at the time of service),
  CO-INSURANCE (an amount - usually a percentage of the office fees that your insurance company will not pay).
- We file claims with our contracted insurance plans only. Since the insurance contract is an agreement between you and your insurance company. It is your responsibility to understand your insurance plan benefits with regard to a covered service, if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure.
- If you have more than one insurance policy, it is your responsibility to inform the office which policy is **Primary** (first) coverage and which policy is **secondary** or **Tertiary**. With each policy, we require the name, birth date, address, phone number, and social security number of the individual who carries the policy.

I agree to provide a copy of my insurance card(s) at each visit with the name, address, phone number, date of birth and social security number of the individual who carries the insurance.

Patient/Responsible Party Initial _____

I agree to provide a valid authorization/referral. I understand that if I do not have a valid referral, the staff may ask me to reschedule or pay for the visit in full at check out.

Patient/Responsible Party Initial _____

General Financial Information

Required Payments: **Any copayment, co-insurance, or deductible required by your insurance company must be paid at time of service.** Because this is an insurance requirement, we **cannot** bill you for these amounts.

Patient/Responsible Party Initial _____

Returned Checks: There is a $50.00 fee for any check returned by the bank. We expect payment by cash, credit card, or money order within 14 days of the notice that your check was returned.

Patient/Responsible Party Initial _____

Past Due Balances: If your account becomes past due (2 or more statements), we will take necessary steps to collect this debt, including referral of your account to a collection agency. An additional 35% of the outstanding balance will be added to your past due amount.

Patient/Responsible Party Initial _____

Treatment of Minor Children:

Children under the age of 18 years must have a parent, guardian or designated responsible party to provide authorization for treatment.

In the case of divorce or separation, it is the authorizing parent's responsibility to collect from the other parent.

It is the authorizing parent's responsibility to provide the office with the name, birthdate, social security number, address and phone number of the parent who carries the child's health insurance.

Patient/Responsible Party Initial _____

Workers' Compensation: We do NOT file worker's compensation claims. Please advise the office staff prior to rooming if you believe your condition is work-related.

Patient/Responsible Party Initial _____

Personal Injury: If you are receiving treatment as part of a personal injury claim or lawsuit, we require verification from your attorney **prior to your initial visit**. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be available. **Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to your personal injury.**

Patient/Responsible Party Initial _____

Completion of Forms: We charge a fee of **$25.00** to complete any forms not related to health insurance claims (disability, FMLA, injury, for example). Payment is due each time you deliver a form for completion. For forms received by fax or mail, we must receive your payment prior to returning the form to the requester. We cannot bill you for this service.

Patient/Responsible Party Initial _____

By initialing and signing this form, you agree to all of the terms and conditions herein and the agreement will be in full force and effect.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Digital Signature	Printed Name	Date
Responsible Party, if not the Patient	Printed Name	Date