

Advanced Ankle & Foot Centers

Financial Policy

Payment of Benefits to the Physician /Provider

I, the undersigned, understand that Advanced Ankle & Foot Centers has agreed to accept Medicare and or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or co-insurance balance after Medicare and or my health insurance payment, which is paid to Ankle & Foot Center of Georgia. I understand that I am financially responsible for any charges not covered by authorization. If I fail to give updated /current information and the claim is denied I will be totally responsible for the entire balance.

Method of Payment

Payment is required at the time the service is rendered. Advanced Ankle & Foot Centers is a participating provider with Medicare, BCBS, and many other "PPO" and "HMO" plans. It is your responsibility to check with your insurance company to see if we are participating provider or to obtain any referrals that may be required by them. Preferred Provider (PPO) and (HMO) medical claims will be filed automatically by our office. Please present your insurance card(s) to our receptionist for photocopying and benefit eligibility verification. You will be responsible for any copay amount at the time of your visit.

In the event your check is returned for any reason, your account will be charged \$30.00. We file your medical insurance as a courtesy. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the account may be referred to a collection agency or attorney.

For your convenience, we accept MasterCard, Visa, Discover as well as cash and checks.

Thank you for taking the time to review our financial policy. Your cooperation is greatly appreciated. If you should have any questions, or require any assistance, we will be pleased to be of service.

I have read this financial policy and understand my rights and responsibilities.

Signature: _____ Date: _____