

Office and Financial Policies: Please read and initial

When you make an appointment with one of our physicians, it is our policy to call your insurance carrier and get your eligibility and basic benefits. If your plan requires that you have a referral prior to seeing a specialist, please present this referral to the front desk before your visit with the physician. If you do not have your referral with you for this appointment, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full.

___Insurance is a contract between You and your Insurance Company. As a courtesy to you, we will gladly file your insurance claim on your behalf. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does not pay within this time, you will be responsible for the entire balance. We have attached a copy of our insurance verification done prior to your visit. Please review these basic benefits and make note of your remaining deductible and copay. These items are due at the time of visit.

___An "Insurance Waiver" maybe required acknowledging understanding of your responsibility for paying for non-covered services. Some insurance companies arbitrarily refuse to cover certain services. Please be prepared to pay for these services in full, or make financial arrangements with our front desk.

___We require a 24 hour advance notice if you must cancel your appointment. Our office assistant will call you 24 hours prior to your appointment to confirm the date and time of your appointment. A missed appointment may be subject to a charge.

___I have read the above office financial policies and I understand theses policies given to me by Advanced Foot Centre.

___I authorize payment of Medical Benefits be made on my behalf to Advanced Foot Centre, for any services furnished to me. I authorize the release of any medical information held by Advanced Foot Centre to the healthcare financing administration and its agents to process my claims.

I HEREBY GIVE MY PERMISSION FOR TREATMENT.

Signature _____ Date _____

ACKNOWLEDGEMENT 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 understood the Notice.

This notice has been posted to our website as well as on display at our facilities.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature