Patient Financial Responsibility Form

Patient Name: _____ Date: _____

Thank you for choosing a Florida Foot and Ankle physician for your podiatry needs. We are honored by your choice and are committed to providing you with the best quality of care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- For your convenience, Florida Foot & Ankle Associates, LLC (FFAA) will bill the patient's insurance for services provided. However, the patient is required to provide FFAA with the most correct and update information about their insurance coverage.
- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and services rendered by FFAA.
- Patients will be responsible for the payment of additional charges incurred but not limited to the following:
    - Charge for returned checks
    - Any costs associated with collection of patient balances
    - Charge for missed appointments without advance notice of at least 24 hours prior to appointment.

MEDICARE AND MEDICAID PATIENT CERTIFICATION-PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title VII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its Intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductible and co-insurance.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form.

_____ _____

Signature of Patient or Guardian Date

CONSENT FOR TREATMENT: I voluntarily consent to the tendering of care, including, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all or part of the physician(s) charges, including but not limited to, Insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

MEDICARE AND MEDICAID PATIENT CERTIFICATION-PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title VII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its Intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductible and co-insurance.

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 understood the Notice.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Print Name of Patient Parent or Authorized Representative

(If Applicable)