

Charlotte Foot & Ankle Specialists, PLLC
2550 W Arrowood Road, Suite #102
Charlotte, NC 28273

Please initial on each line before each paragraph acknowledging you understand our policies. Even if, it does not apply to your situation at this time.

_____ For patients with insurance, **Co-payments, co-insurance, unmet deductibles and non-covered services or supplies are due at the time of service.** If your insurance fails to respond to the claim within **60 days**, Charlotte Foot & Ankle Specialists (CFAS) reserves the right to collect full payment from the patient.

_____ If you have Medicare and have changed to an HMO Insurance policy (Medicare replacement plan) you must provide this information to the front desk. **Co-payments, co-insurance, unmet deductibles and non-covered services or supplies are due at the times of service.** If we do not participate with your HMO plan, you may be responsible for payment in full if there is not an out of network benefit. If you fail to disclose correct insurance information to us, you will be responsible for payment.

_____ For patients without insurance or on a plan we do not participate with: CFAS financial policy require payment in full at time of service. **If you do not have your insurance card with you and we are unable to verify benefits, you will be responsible for paying at the time of service.**

_____ If you are unable to pay your balance in full when due, you need to contact us immediately. Failure to make payment on your account as required every 30 days, will require further action to collect the balance in full and your credit rating will be affected. If regular monthly payments are not received and no payment arrangements have been made, we will no longer be able to extend credit to you for future visits. **An additional collection fee of 35% will be added to the outstanding balance at the time of transfer to a collection agency.**

_____ Please be aware that you will incur a \$25 fee if you fail to show up for your scheduled visit or if you cancel or reschedule your visit less than 24 hours prior to the scheduled time.

_____ Please be aware that we charge \$15 for the completion of any patient forms (ie: FMLA, disability)

Medicare/Medicaid Patient's Certification: I certify the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to CFAS. I authorize CFAS to release any medical information including complete medical records, test results and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate or make payment of a claim and to review records for quality improvement initiatives, audit compliance, utilization management and complaint resolutions.

Assignment of Benefits: I hereby authorize payment directly to CFAS for all medical or surgical benefits otherwise payable to me under terms of my insurance.

Patient or Responsible Party's Signature

Date

Thank you for complying with these policies so that we can keep your costs as low as possible!

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We recognize how difficult it is to understand many of the points in today's insurance policies, with new plans and companies emerging constantly. Our office staff will make every attempt to follow the guidelines required by your insurance company. However, please understand the **contract is made between the insurance company and the patient.** Therefore, it is the **patient's responsibility** to know and understand the details of his/her specific coverage.

Thank you for choosing us as your foot care provider.
Discover, MasterCard, Visa and Debit Cards accepted