McKenzie-Hastings Institute For Foot & Ankle Surgery Financial Policy

Patient Name:_____Birthdate:_____

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept cash, check, Visa, MasterCard and Discover.

2. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, our billing company will file your insurance claim if you assign the benefits to your doctor. If your insurance company does not pay the practice within a reasonable period, the practice will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. Our billing company will bill your insurance company, per your contract with your insurance company, you will be required to pay your copayment at the time of your visit.

4. If you have not met your deductible, you are required to pay $200.00 prior to your initial visit with the doctor.

5. If you are a self-pay patient with no insurance, you are required to pay $200.00 prior to your initial visit with the doctor. This is a down-payment on your account only. As a courtesy to you, all additional fees will be billed to you by our billing company.

6. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an "unassigned" basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

7. Not all insurance plans cover all services. In the event your insurance plan determines a service not to be covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our billing company.

8. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

9. I authorize the release of any medical information to process my insurance Claims. I authorize and request payment of medical benefits directly to Dr. Heather McKenzie or Dr. Charles Hastings. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that an electronic or photocopy of this form may be used in place of the original. I accept full financial responsibility for all expenses of collection, if necessary, including the $33^{1/3}$% of any attorney fees and court costs.

I have read and understand the practice's financial policy and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature:_____Date:_____