Elite Foot and Ankle

Financial Policies

Financial policies

Please place your initials by each of the statements below to designate that you have read and understand the financial policies of this practice.

__________ **I understand that I am responsible for determining if Elite Foot and Ankle is a participating provider with the network affiliated with my insurance company. I am aware that if Elite Foot and Ankle is an out-of-network facility, I may be responsible for greater out-of-pocket expense.**

_________ **I understand that I am responsible for determining if my insurance plan requires a referral from my family physician. I understand that it is my responsibility to obtain any referral required by my insurance company from my family physician prior to being seen by Elite Foot and Ankle. If I do not obtain a referral from my family physician and one is required by my insurance company, I understand that I will be responsible in full for all charges not covered by my insurance.**

__________ **I understand that I am responsible for payment of my co-pays up front. I understand that I am also responsible for any deductibles/co-insurance on services rendered.**

__________ **I understand that it is my responsibility to provide ALL of my insurance information at the time services are rendered. If claims are later denied due to being past the filing limit or if charges are denied by a secondary plan for failure to provide primary insurance information timely, I will be responsible in full for the charges incurred.**

__________ **I understand that there is a $20.00 fee associated with completion of disability forms and/or FMLA paperwork.**

I agree to adhere to the above financial policies. By signing below, I accept the terms and conditions of these policies.

____ ______________________
Patient/Responsible Party Signature **Date**