PATIENT FINANCIAL RESPONSIBLITY POLICY/No Show Policy

Thank you for choosing Infinity Foot and Ankle for your podiatric care needs. We are committed to providing you with the highest quality care. Every patient must be thoroughly informed of their treatment options and the financial obligations for a particular service. Please carefully read and then sign this form to acknowledge your understanding of your financial obligations related to your treatment. If you should have any questions regarding our financial policies, please ask our office staff before signing this document.

The following is our payment policy, which we require you to read and sign prior to your visit(s).

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.

Patients have many different types of insurance and payment options for services rendered. Also, not all podiatrists in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your insurance identification card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or insurance information. Patients without insurance are required to pay in full at the time of service. For your convenience, we accept Visa, Mastercard, and personal checks. Please be aware that Returned Checks will incur a $50.00 service charge.

Participating Plans: You must present your insurance card when requested and if applicable, your insurance referral form, at every visit. We will submit your medical claim directly to your insurance company for payment on your behalf. Full payment at the time of service is expected for all patients without insurance or those covered under plans which we do not participate in.

Non-Covered Services: If your provider does not participate in your insurance plan or your services are not covered by your insurance plan, you are responsible for payment of all charges at the time of service.

Copayments or Deductibles: All co-pays, co-insurance, deductibles, and non-covered services will be collected at the time of service. I understand that I am responsible for paying my provider directly for any applicable deductibles/copayments/coinsurance.

Cancellations and Missed appointments: Our Policy is to charge for missed appointments not canceled within 24 hours of your appointment. The missed appointment fee of $50.00 will be your responsibility and billed directly to you.

Nonpayment: If your account is over 60 days past due, you will receive a statement stating that you have 30 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During those 30 days, we will only be able to treat you on an emergency basis.

I authorize payments to be made directly to Infinity Foot and Ankle, PA and fully understand that I am the party responsible for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. I have read the "Financial Policy"; I understand and agree with it. By my signature below, I hereby authorize the assignment of financial benefits directly to IFA for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I understand that Infinity Foot and Ankle and its physicians are not ultimately responsible for collecting from my insurance or negotiating settlement of claims. I understand the financial policies and accept responsibility for payment of any balance owed on my account. I understand that I am financially responsible for all charges whether or not paid by insurance.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Policy:

_____ _____

Patient Name Date of Birth

_____ _____ _____

Signature of Responsible Party Relationship to Patient Today's Date