FINANCIAL AGREEMENT

I UNDERSTAND AND AGREE TO THE FOLLOWING:

FINANCIAL RESPONSIBILITY: I am responsible for the cost of all health care provided to me by The Foot and Ankle Center. The Foot and Ankle Center Center will, upon request, provide an estimate of the cost of care for the services I am likely to receive, with the understanding that such amount is only an estimate and the actual cost of care may be lower or higher.

INSURANCE: If I have health insurance, I must pay any deductibles and co-payments at the time services are provided. If The Foot and Ankle Center is contracted with my insurance company, The Foot and Ankle Center will, as a service to me, bill my insurance company directly and I hereby assign all insurance reimbursement payments to The Foot and Ankle Center. I will be responsible for the full cost of my care if insurance coverage is denied and for all amounts not paid by my insurance company. Such amounts will be due upon my receipt of a bill or statement from The Foot and Ankle Center. I will be responsible to pay any amount that is not paid by my insurance company even if my treatment was pre-authorized by The Foot and Ankle Center and/or my insurance company. If The Foot and Ankle Center is not contracted with my insurance company (e.g. travel insurance) or if a third party may be responsible to pay for my care (such as in an automobile accident), the account balance will be billed to me in full. I must seek reimbursement from the insurance company or third party.

LATE PAYMENTS: If my account is referred to a collection agency, I agree to also pay late charges, interest, reasonable attorney fees and collection costs.

MEDICARE/MEDICAID PATIENTS: I certify that all information I provide The Foot and Ankle Center for the purpose of applying for reimbursement under the Social Security Act is correct and I authorize all holders of my medical and other information to release such information to the Social Security Administration, its intermediaries and carriers for such purposes. I request that authorized benefits for services provided by The Foot and Ankle Center be paid to The Foot and Ankle Center on my behalf.

PROVIDER-BASED CLINICS: I will receive two bills for outpatient services I receive at The Foot and Ankle Center and at certain Foot and Ankle Center clinics-one bill is for professional services and the other bill is a facility fee. I will be responsible to pay both bills. If I have insurance, I may have a separate co-insurance and/or co-payment for each bill.

By Signing below, I agree that I have read this form and/or had it explained to me. I have asked any questions about any part of the form that is unclear to me, understand the answers, and agree to the terms stated. If I am signing on behalf of a patient, whether as the patient's parent, guardian, or other representative, I am authorized to sign on behalf of the patient.

Patient: ______________________ ______________________ **Date:** ______________

Signature **Printed Name**

If signed by a person other than the Patient, my relationship to Patient is:

- O Spouse
- O Health Care Power of Attorney
- O Parent
- O Legal Guardian
- O Adult Child
- O Adult Brother/Sister

For Minor Patients:

- O Parent
- O Guardian/legal custodian
- O Court-authorized person for child
- O Other (please describe): ______________________________