Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

____**CO-PAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

____**DEDUCTIBLES & CO-INSURANCE**: If you have a high deductible plan, we will collect a $125 deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

____**SELF-PAY:** Full payment is due at the time of service. A down payment will be required before seeing the doctor. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.

____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we will need to reschedule your appointment.

____**NO SHOW:** 24 hours notice is required for cancellation of your appointment and failure to do so will incur a $50 fee. Failure to provide 24 hours notice of a procedural visit will incur a $100 fee.

____**SURGERY CANCELLATION:** Failure to provide 5 business days notice before surgery will incur a $300 fee.

____**BALANCES/COLLECTION FEES:** If balance is not collected within 30 days from the postmark date of a mailed statement, a $12 re-billing fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a $35 administrative fee will be added.

____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a $25 charge for having the doctor complete these forms. There is a $10 fee to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient Name (print):_____

Patient/Responsible Party Signature:_____

Date:_____

CREDIT CARD ON FILE AGREEMENT

Patient Name:_____

Date of Birth:_____

District Foot and Ankle, PLLC will securely save a credit card on file for any balance due. Once insurance benefits have been applied, a statement will be mailed to the patient. The credit card will be charged if after THIRTY days of the statement date, a balance remains.

The credit card information will be stored securely and cannot be viewed once entered into our system.

I agree to keep my credit card information on file with District Foot and Ankle, PLLC. As stated above, my credit card will be charged only if my balance is not paid within 30 days of the statement date.

Last 4 digits of credit card:_____

Expiration Date:_____

Cardholder Signature:_____

Date:_____