

EAST VALLEY FOOT & ANKLE SPECIALISTS

NAME _____

DATE _____

PAYMENT INFORMATION:

PRIMARY INSURANCE

NAME _____ **GROUP#** _____

POLICYHOLDER _____ **ID#** _____

EMPLOYER _____ **SS#** _____ **DATE OF BIRTH** _____

RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD

SECONDARY INSURANCE

NAME _____ **GROUP#** _____

POLICYHOLDER _____ **ID#** _____

EMPLOYER _____ **SS#** _____ **DATE OF BIRTH** _____

RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD

Is this a work related injury? _____ If yes, date of injury _____

Is your injury related to an auto accident? _____ If yes, date of accident _____

Please explain how your injury occurred, if not work related? _____

AUTHORIZATION TO TREAT/RELEASE OF INFORMATION:

1.) I hereby give my permission to Dr. Lewis Freed, Dr. Douglas Griffin, Dr. Todd Gunzy, Dr. Todd Haddon and Dr. Scott Wyant to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account. I also authorize the above physicians to release all information required in the processing of my claims.

2.) I authorize my consent to the East Valley Foot and Ankle Specialists, to call and remind me of upcoming appointments or to make follow-up calls after treatment.

PRINT NAME: _____

SIGNATURE: _____ **DATE** _____

Patient Financial Policy

Your understanding of our **financial** policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

As our patient, you are responsible for all **authorizations/referrals** needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, Mastercard, Discover, cash or check.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

- There is a service fee of \$25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ **Date:** _____