MARIAN DAVIS DPM PA

Marian Footcare

WWW.MARIANFOOTCARE.COM

Acceptance of Insurance Assignment and Financial Policies

Please initial each line showing you agree to abide with the following:

____ I authorize [MARIAN DAVIS DPM PA] and its agents to furnish my insurance companies with all necessary information concerning diagnosis and treatment for myself or dependents under compliance of the Health Insurance Portability and Privacy Act of 1996 (HIPAA).

____ I assign the medical and/or surgical benefits that my dependents and I are entitled to under my health insurance plan to [MARIAN DAVIS DPM PA] and treating physicians.

____ An estimate will be provided before any services are rendered.

____ I agree to pay all balances accrued with [MARIAN DAVIS DPM PA] and my treating physicians for services rendered. Cash, personal checks, cashier's checks, money orders, VISA, MasterCard, and Discover are accepted. Other payment agreements set forth by my insurance plan may restrict or limit the ability of [MARIAN DAVIS DPM PA] to collect payment in full.

____ I understand I am responsible for all co-payments, deductibles and coinsurance. Co-payments must be paid prior to services being rendered. If I do not know the exact co payment or outstanding deductible amount for the current calendar year, then I will pay a minimum of $60.00 prior to receiving care.

____ I understand some medical/surgical and/or durable medical equipment services will require a pre-paid deposit. All deposits will be applied to any outstanding charges for those services rendered. Any excess funds remaining after receiving insurance remittance will be refunded promptly.

____ [MARIAN DAVIS DPM PA] does not generally arrange payment plans. In situations of extreme financial hardship, discuss your situation with the treating physician and/or the office manager and the office would decide if a payment plan will be offered to you.

____ I understand that I am responsible for any outstanding balance remaining after insurance remittance has been received. A collection fee of 5% will be applied to outstanding balances past 90 days. Any balance not paid after 150 days may be referred to an attorney for collection. All legal and collection fees will be the guarantor's responsibility.

____ In the case of divorced parents, payment is expected from the person signing this document and will be considered the guarantor for all payments for any services provided. [MARIAN DAVIS DPM PA] will not recognize any divorce decrees regarding reimbursement for medical services for any minor child of divorced parents.

*** (College students with parent's insurance, please initial below)***

____ College students with health insurance under their parent's name will not be treated by any physician from [MARIAN DAVIS DPM PA] without written permission from parent or guardian. Original signature or fax is allowable. The student being treated gives permission to [MARIAN DAVIS DPM PA] to contact parents regarding his or her health conditions per HIPAA requirements. Parents agree to be responsible for all charges unless other arrangements are made in advance.

___«PatientFullName»_ _____

Patient Name Date

_____ _____

Signature of Patient/Responsible Party Date

MARIAN DAVIS DPM PA

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