CENTER FOR FOOT & ANKLE SURGERY, LLC

655 Shrewsbury Ave. Ste 207 Shrewsbury, NJ 07702 (732) 741-5500

OFFICE POLICY

Patient Name: ____
(Please print)

I understand that it is my responsibility to know my insurance policy with regard to physician participation, required referrals and covered services by my insurance company.

I am fully aware that it is my responsibility to provide your office with a written referral from my primary care physician if my insurance plan requires one. If I do not present a referral at the time of my office visit, I am responsible for all charges incurred.

I understand also that confirmation of coverage, as well as an authorized referral, does not guarantee payment from my insurance company and that I will be responsible for any charges not covered by my insurance plan.

I agree to pay any co-pays and /or deductibles as per my insurance plan and that if I receive a bill from your office I am required to pay it within a **thirty** day period. If there is a problem with the charges I will notify your office promptly within thirty days. If I am unable to pay the full amount within a thirty day period I will call your office to set up a payment plan.

I hereby authorize the Center For Foot & Ankle Surgery, LLC to furnish information concerning my illness and treatment to my insurance company, attorney, school, or other treating physician. I also hereby assign the Center For Foot & Ankle Surgery, LLC payments for medical service rendered to myself. I understand that I am responsible for any amount not covered by insurance and that the Center For Foot & Ankle Surgery, LLC requires payment at the time of treatment unless prior arrangements have been agreed upon.

No Show Policy: There will be a $25 charge to all patients who do not show for their scheduled appointment. Cancellations must be made 24 hours prior to appointment.

____ ____________
Signature of responsible party Date

PATIENT LIABILITY AGREEMENT

I understand that I am financially responsible for all bills incurred while under the care of Center For Foot & Ankle Surgery. In the event that my account is not paid in full, I shall be liable for any and all costs of collection, including, but not limited to a 35% fee of the outstanding balance if my account is forwarded to a collection agency for collection. If my account is forwarded to an attorney for legal proceedings I agree to be liable for an additional attorney fee making a total collection and attorney fee of 50% of the outstanding balance.

I further understand that there shall be a 1.5% interest charged per month on any outstanding balance that is forwarded to collection.

By signing below, I hereby indicate that I have read and understand the terms of this contract.

Please Initial:

________ I understand there will be a 35% collection fee on the outstanding balance if my account is forwarded to a collection agency.

________ I understand there will be a 50% combined collection and attorney fee if my account is forwarded to an attorney for legal proceedings.

________ I understand there will be 1.5% interest per month on any outstanding balance that is forwarded to a collection agency.