COUNTRY FOOT CARE PODIATRY, P.L.L.C.
FINANCIAL RESPONSIBILITY FORM

INSURANCE COVERAGE
It is patient's responsibility to be aware of insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier. We attempt to verify that patient's coverage is valid at the time of service. However, if coverage is not in effect at time of service, patient is responsible for payment.
INSURANCE CHANGES
It is patient's responsibility to inform this office of any changes in address, phone number and insurance information. Outstanding balances for co-pays, co-insurances, deductibles and denials due to change in coverage or non-participating plans are patient's responsibility. If incomplete or incorrect information is provided to us, and the insurance company does not make full payment, patient will be responsible for any outstanding balances not received by our office.
CO-PAYMENTS, CO-INSURANCES, DEDUCTIBLES AND BALANCES
Patient assigns all insurance benefits to be paid directly to the practice named above.
Co-payments, co-insurances and deductibles are patient's responsibility. Co-payments are due at the time of service. Patient's responsibility for deductible amounts may not be determined at time of service and a best estimate payment by patient at time of service may be required. Any deductible balance owed will be billed to patient at a later date. Co-pays not paid at time of service and all unpaid balances which require a patient billing statement may be subject to additional monthly processing fees of $25.00.
Patient authorizes this office to utilize all contact information listed below without restriction as to day or time as may be necessary regarding medical and/or financial matters.
Patient authorizes this office to retain credit card information on file and to charge credit cards for any balances as they become due.
REFERRALS
Patient assumes full responsibility for obtaining any necessary referrals required by insurance.
If patient has not received the necessary referrals and the insurance company does not pay any claims, patient will be responsible for any and all Country Foot Care Podiatry P.L.L.C. billings.
NON-COVERED SERVICES
All patients are responsible for "non-covered" services if denied by their insurance carrier.
INSURANCE REQUESTS
Patient is responsible for responding to requests from the insurance company for further information. Not doing so results in claim denial and patient will be responsible for payment.
INSURANCE PAYMENTS SENT TO PATIENT
All insurance payments mailed to patient must be forwarded to this office by patient.
CANCELLATION POLICY
If you do not cancel or reschedule your appointment with at least 24 hours notice, a "no show" service charge will be assessed to your account for each missed appointment.
REFUNDS
There are no refunds given on any retail items or medical procedures not covered by insurance.

I have read and understand this financial responsibility form.

Patient Signature:_______________________________

Responsible Party (if not patient):____________________