Prince William Foot & Ankle Center, P.C. / South Riding Foot & Ankle Center

Private Insurance Authorization for Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to Prince William Foot & Ankle Center, PC for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by the contract. I also authorize you to release to my insurance company information concerning health care, advice treatment or supplies provided to me. This information will be used for the purpose of evaluating and administrating claim benefits. I permit a copy of this authorization to be used in place of the original.

Financial Policy

Payment or proof of valid insurance is due at the time services are rendered unless payment arrangements have been approved in advance by the Office Manager.

________***Full payment is due at the time of services, which may include deductibles, co-insurance and co-payments.***
As a courtesy, we will submit your claim for all services to your insurance company.

________**Please remember your individual health insurance policy is a contract between you and your insurance company, and we are not a party of that contract.**

________**Be aware that some of our services may not be covered by your insurance policy.**
By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status.

________**Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.**

If your Insurance Company requires a referral it is your responsibility to submit a **valid** referral upon checking in with the front desk. If you do not have a valid referral you will be responsible for full payment of services rendered.

Should your account become past due, you will be responsible for any finance charge or legal fees necessary to collect on this account. A Valid Collection Charge of 33% will be assessed if sent to Collections. A fee of $35 will be assessed for all returned checks. You may also be charged a fee if you do not show up for an appointment or cancel an appointment without giving 24 hours' notice.

Acknowledgment of Receipt of Notice of Privacy Practices (HIPPA)

I acknowledge that I was provided a copy of privacy practices and that I have read (or had the opportunity to read) and understand this policy.
I am also aware that a notice of privacy practices is posted in the reception area of Prince William Foot & Ankle Center, PC.

***Signature (EVERYONE)**: ____ Date: _____/_____/___________

****MEDICARE ONLY**MEDICARE ONLY**MEDICARE ONLY**MEDICARE ONLY** MEDICARE ONLY**MEDICARE ONLY**MEDICARE ONLY****

Medicare Lifetime Signature on File

I request that payment of authorized Medicare Benefits be made either to me or my behalf to Prince William Foot & Ankle Center, PC for any services furnished to me by the physician. I authorize any folder of medical information about me to be released to the Health Care Financing Administration and any agency information needed to determine these benefits or benefits payable for related services.

***Signature (MEDICARE ONLY):** ____ Date: _____/_____/___________