ADVANCED
FOOT & ANKLE

176 Falls Ave Ste 200
Twin Falls, ID 83301
PH: 208-731-6321

Financial Policy, Responsibility, Consent for Treatment,and Assignment of Benefits

Thank you for choosing our practice for your healthcare needs. We are committed to providing high-quality care in a transparent and professional manner. Please review the following:

I certify that I am the Patient or the legally authorized representative of the Patient. The following consents, acknowledgments, and agreements are on my behalf, or on behalf of the Patient, as a condition of receiving healthcare services from Advanced Foot & Ankle.

Consent for Services: I hereby consent to and authorize Advanced Foot & Ankle, its physicians, staff, and employees, to provide medical care and treatment to the Patient.

I**nsurance Billing:** We will bill your insurance as a courtesy. However, insurance is a contract between you and your insurance company, and you are ultimately responsible for all charges. Please understand your benefits, including deductibles, co-payments, co-insurance, and non-covered services. We cannot guarantee insurance payment. Co-Payments, Co-Insurance, and Deductibles: All co-payments, co-insurance, and unmet deductibles are due at the time of service. The Patient is responsible for obtaining any required referrals or prior authorizations from their insurance carrier, including those from a primary care provider, to ensure proper reimbursement.

Authorization: I request payment of authorized benefits to Advanced Foot & Ankle for services provided. I authorize the release of any medical or other necessary information to Medicare, Medicaid, TRICARE, CHAMPVA, or other applicable entities to determine benefits and process claims.

Assignment of Benefits: I hereby assign and authorize direct payment to Advanced Foot & Ankle of any insurance or third-party benefits payable for services rendered. This assignment applies to all payments for healthcare services provided to the Patient. If payments are made directly to the Patient, I agree to promptly forward such payments, along with the Explanation of Benefits, to Advanced Foot & Ankle within 10 calendar days.

Non-Covered Services: If a service is not covered by your insurance, you are responsible for the full balance. You may be asked to sign an acknowledgment for certain non-covered services.

Self-Pay Patients: Payment in full is expected at the time of service unless prior arrangements are made. You may request a Good Faith Estimate of expected charges.

Patient Responsibility: Any balance remaining after insurance processing is your responsibility and is due upon receipt of your statement. Repeat statements may be subject to a $5.00 rebilling fee.

Delinquent Accounts: All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum.) In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees. You agree, that in order for us to service our account, we may contact you by text or telephone at any telephone number associated with your account, and/or the email you provide. Payment plans may be available upon request and must be agreed upon in writing.

Missed Appointments: At least 24 hours' notice is required for cancellations. Missed or late-canceled appointments will result in a $50.00 fee not covered by insurance.

Returned Checks: A returned check fee of $25.00 will be applied.

ACKNOWLEDGMENT OF FINANCIAL POLICY AND SIGNATURE: I certify that I have read and understand this document. I acknowledge that I am financially responsible for all services provided. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I understand my rights and responsibilities and agree to the terms outlined above. I acknowledge that I may request a copy of this document.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Witness Signature:_____

GUARANTOR AGREEMENT: (If Applicable)I agree to serve as the guarantor for the patient and accept full financial responsibility for all charges incurred.

Guarantor Name (Print): _____

Guarantor Signature: _____