InStride Roberson Foot Care

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FINANCIAL POLICY

Our objective is to provide you with the highest quality healthcare in the most cost effective manner. However the ability of Roberson Foot Care to achieve this objective depends greatly on your understanding of our financial policy. If you have medical insurance we will file insurance claims on your behalf. We do this as a courtesy to our patients and are anxious to help you receive the maximum allowable benefits from your insurer.

MEDICARE PATIENTS: As a participating provider of Medicare Plan B (Physician Services), Roberson Foot Care will only bill you for your Medicare coinsurance, deductible and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare. **You will be required to pay the co-pay and deductibles for authorized services at the time of service.**

NOTE: You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare Waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services.

If you have Medicare Part A only, then the services you will receive from our practice will not be covered by Medicare.

COMMERCIAL INSURANCE PATIENTS: Remember that your insurance contract is between you and your insurer. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. **You will be required to pay the co-pay and deductibles for authorized services at the time of service.**

HMO/MANAGED CARE INSURANCE PATIENTS: Many HMO/Managed Care plans require that you obtain a referral in order to receive care from a specialist. It is your responsibility for obtaining this referral if needed. Unauthorized services will be the financial responsibility of the patient. **You will be required to pay the co-pay and any deductibles for authorized services at the time of service.**

PATIENT WITH NO INSURANCE: Patients with no insurance are required to pay for all services related to their visit in full at the time of service.

CANCELLATION/NO SHOW POLICY: A $50 fee will be charged if you fail to cancel your appointment without a 24 hour notice or if you fail to come to your scheduled appointment (no show).

We accept VISA, MasterCard, CareCredit, Check or Cash.

COMMERCIAL INSURANCE ASSIGNMENT AND RELEASE _____**(initial)**
I, the undersigned, certify that I (or my dependent) have insurance coverage as provided to the office and assign directly to Dr. Ainsley Roberson Rusevlyan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

MEDICARE AUTHORIZATION _____**(initial)**
I request that payment of authorized Medicare benefits be made on my behalf to Dr. Ainsley Roberson Rusevlyan for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form,or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Patient/Guardian Signature Date