Foot & Ankle Clinic

Of Central Nebraska

Financial Agreement

Patient Financial Responsibility: I understand I am directly and primarily responsible to pay the amount of all charges incurred for services provided by the Foot & Ankle Clinic of Central NE. Elective procedures, including but not limited to Shockwave and Laser Treatments, require payment in full upon the first treatment. In the event of a surgical procedure, I understand there may be a down payment requirement.

No Insurance: Payment will be due at time of service.

Insurance and Claim Filing: I understand the Foot & Ankle Clinic of Central NE will file a claim for with my insurance plan(s) as a courtesy to me. The Foot & Ankle Clinic of Central NE does not accept responsibility for negotiating claims with my insurance company. If my insurance company requires copayment, I understand that it must be made upon check in prior to my appointment. The Foot & Ankle Clinic of Central NE will pre-authorize surgical services provided at the hospital or surgical center with my insurance plan to determine coverage based on medical necessity.

I understand that the Foot & Ankle Clinic of Central NE does not accept insurance payments as payment in full. I am responsible for any deductible, copayment or coinsurance, as well as for all non-covered or denied services by my insurance company.

Foot & Ankle Clinic of Central NE will file third party liability and motor vehicle claims upon request with appropriate information. If my insurance company fails to pay the Foot & Ankle Clinic of Central NE in a timely manner for any reason, I understand that I will be responsible for prompt payment of all amounts owed to the Foot & Ankle Clinic of Central NE.

Authorization/Assignment of Benefits: I authorize the release of any medical information necessary to process my insurance claim. I authorize payment of medical benefits to the Foot & Ankle Clinic of Central NE for services rendered.

Collections: If my account is referred to collection agency or attorney for collection related matters, I understand that I am responsible for all costs associated with the collection agency, as well as any legal fees. If collection action is taken on my account, I also understand that I may not be able to continue receiving medical care at the Foot & Ankle Clinic of Central NE and that my relationship with my provider may be at risk.

I have read and understand this financial agreement.

Patient Name(Print) ____ **Date of Birth** ________________

Signature(Patient) ____ **Date** ________________________

Or

Signature(Patient's Guarantor) _______________________________________ **Date** ________________________