FLORIDA FOOT & ANKLE ASSOCIATES

Patient Financial Responsibility Form

Patient Name:_____ **Date:**_____

Thank you for choosing a Florida Foot and Ankle physician for your podiatry needs. We are honored by your choice and are committed to providing you with the best quality of care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- For your convenience, Florida Foot & Ankle Associates, LLC (FFAA) will bill the patient's insurance for services provided. However, the patient is required to provide FFAA with the most correct and updated information about their insurance coverage.
- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and services rendered by FFAA.
- Patients will be responsible for the payment of additional charges incurred but not limited to the following:
  - Charge for returned checks
  - Any costs associated with collection of patient balances
  - Charge for missed appointments without advance notice of at least 24 hours prior to appointment.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Signature of Patient or Guardian **Date**

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Print Name of Patient