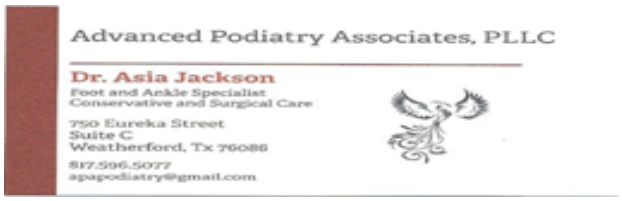



## Financial Responsibility

Durable Medical Equipment, orthodics, in-office surgery (including injections) and physical therapy are often not covered by even the most comprehensive medical insurances, including secondary to Medicare. Unfortunately, this can result in out-of-pocket expenses for you or your family. It is our policy to communicate with your insurance company to help you avoid any circumstances where you would unknowingly have out-of-pocket expenses due to non-covered benefits, deductibles, copays and coinsurance. By signing below, you assume full responsibility for all allowable charges not covered by your medical insurance.

Please contact your insurance company in advance if you have any questions about what expenses you may incur. If your insurance will not allow a service provided by our office and you prefer not to pay out-of-pocket, please let us know so we can discuss other options.

_____ _____

**Signature of Patient (or Parent/Guardian)** **Date**

**********

## Advanced Podiatry Associates Signature Authorization

**Information Release**

I authorize the providers of Advanced Podiatry Associates, PLLC to release any information obtained in the course of my evaluation and/or treatment to my insurance company(ies), primary care physicians, and/or attorney(s). I further authorize any other medical provider of services to release full details of your condition to Advanced Podiatry Associates, PLLC for the purpose of medical treatment.

initials _____

**Direct Payment**

I authorize payment directly to Advanced Podiatry Associates, PLLC for the amount due in my pending claim for podiatry expenses payable under the terms of my insurance. I agree that I am responsible for any services or supplies that may not be covered by my insurance.

initials _____

**Balance Payment**

I agree that I am responsible for any balance not paid by my insurance, (including Medicare secondary insurance). I understand that if I fail to resolve any balance determined to be my responsibility, my account may be forwarded to collections.

initials _____

**Photographic and Radiological Release - Clinical Records**

I authorize the providers of Advanced Podiatry Associates, PLLC to take necessary clinical photographs and X-rays with the understanding that such records are for confidential clinical purposes only. If my insurance company requires medical records to process my claim, I authorize the release of my records for that purpose.

initials _____

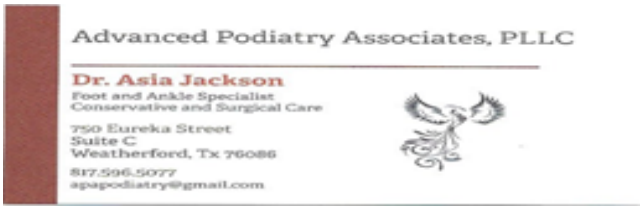
**Change of Information**

I will use best efforts to notify Advanced Podiatry Associates, PLLC of any change to my information (address, phone numbers, insurance company etc) in a timely manner. Should I fail to notify Woodly Foot and Ankle Specialists, PC of a change in my insurance carrier, I agree that I will be responsible for any charges not payable due to my failure to obtain any necessary referrals, authorizations, and/or coverage benefits. I realize that this is my responsibililty when seeking the care of a specialist.

initials _____

**I have read and fully understand the above statements. I agree that I am bound and hereby give my consent.**

Patient Signature (Parent or Guardian) Date




**Statement of Financial Responsibility**

**Please read and sign**

**I understand that I am responsible for any charges incurred during any visit or treatment by the doctors and staff of Advanced Podiatry Associates, PLLC**

initials _____

My insurance company may not cover my charges for the following reasons: My insurance company may not cover the service, my insurance may not be in effect, the charges may be applied to my deductible/co pay and/or coinsurance, I did not bring a referral for this care, the referral did not arrive in time for the visit or for any other reason deemed by my insurance.

initials _____

As a courtesy to me, the staff of Advanced Podiatry Associates, PLLC will make every effort to verify my insurance, its benefits and coverages, **however**, it is my responsibility to verify my plan's network, benefits and coverages for services provided by Advanced Podiatry Associates, **The doctors and staff of Advanced Podiatry Associates, PLLC will file my insurance when appropriate, but I will be ultimately responsible for all charges.**

initials _____

**I understand that payment is due at the time of service.** I understand that my account will be turned over to collections if payment is not made after 61 days of 1st bill from Advanced Podiatry Associates, PLLC.

initials _____

*****24 HOUR APPOINTMENT CANCELLATION NOTICE IS REQUIRED*****

***I Understand that a Fee of $30.00 will be accessed to my account if I fail to provide a 24 hour cancellation notice resulting in a missed appointment.***

initials _____

**X**_____ _____

**Patient/Parent/Guardian Signature**

**Services will not be provided without a signed financial statement**

:**********