Podiatric Medicine, Surgery and Wound Care.

FINANCIAL ACKNOWLEGDEMENT & AGREEMENT

PLEASE READ CAREFULLY AND SIGN BELOW:

Your understanding of our financial policy is an essential part of your treatment. By signing this agreement, you acknowledge herewith, that you have **voluntarily** entered into a financial agreement with STRIDE FOOT & ANKLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services.

Insurance: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible or Non-Covered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit.
Co-Pays: All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date.
Uninsured patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of **$200** prior to receiving services. This amount can be paid in cash, debit/credit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed $200, payment is required at that time.
Referral: You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.

Please initial each statement:
____I authorize release of information to all insurance companies
____I authorize and direct payments of podiatric services directly to Stride Foot & Ankle Center, LLC
____ I understand that a **$40** No Show fee will be charged if I don't cancel or reschedule my appointment within 24 hours.
____ I understand that there is a **$40** charge for returned checks (NSF) and that in such event, I will no longer be able to pay with check for future appointments.
____ I understand that balances 30 days overdue will incur a 1.5% late fee per month and are subject to collection report.
I have read, understood and accept the terms stated above. I have been given a copy of this financial acknowledgement.

______________________	______________________________
Printed patient name	Patient Signature/Responsible Party
_____________________	______/_______/_______
Office staff	Today's date