Central Florida Foot & Ankle Specialists, PA

Victor F. McNamara, DPM, FACFAS, FCCWS

OUR FINANCIAL POLICY

Thank you for choosing Dr. Victor F. McNamara as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment; timely payment is imperative in assuring the continuation of the lowest possible cost to you.

All patients must complete our "Patient Information Form" before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, MASTERCARD, VISA AND DISCOVER. _____Patient Initials

REGARDING PRIVATE INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, you are financially responsible for your initial visit in full at time of service. On your subsequent visits we will gladly file your insurance claims for you. You will be responsible to meet any deductibles, coinsurance, supplies and non-covered services at time of service. Any balance remaining after your insurance company pays is your responsibility. If your insurance company has not made payment within 45 days, the balance will be transferred to your responsibility. _____Patient Initials

In the event a credit balance is present on your account, reimbursement will be processed within 30 days.

REGARDING MEDICARE

We accept Medicare assignment. We will file your Medicare claims for you. With Medicare, you are responsible for any deductibles, coinsurance, supplies, and/or non-covered services at the time services or procedures are rendered. _____Patient Initials

REGARDING HMO, PPO, AND MANAGED CARE INSURANCE

If we are contracted with your HMO, PPO, or Managed Care insurance, insurance claim filing will be automatic. You will be responsible for any deductibles, coinsurance, co-payments, supplies, and/or non-covered services at the time services or procedures are rendered. _____ Patient Initials

MINOR PATIENTS

All minor patients must be accompanied by a parent or legal guardian or treatment will not be rendered. _____ Patients Initials

MISSED APPOINTMENTS

Your appointment time is reserved exclusively for you. We require 24 hours notice if unable to keep your appointment. Cancellations or broken appointments without 24 hour notice will be subject to a broken appointment fee of $25.00.
_____Patient Initials

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the Financial Policy above._____ Patient Initials

SIGNATURE ON FILE FORM

I understand that I am responsible for payment of services provided to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Central Florida Foot & Ankle Specialists, P.A. for Professional Physicians fees. I authorize release of medical information for insurance purposes. I understand that I am responsible for charges not covered by my insurance policy.

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made to Central Florida Foot & Ankle Specialists, P.A. on my behalf for any services furnished by Central Florida Foot & Ankle Specialists, P.A. 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 to related services. In Medicare assigned claims, 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 their deductible, coinsurance, and non-covered services.

I understand my signature authorizes that payment be made to Central Florida Foot & Ankle Specialists, P.A. for my medical claims and authorizes release of medical information necessary to process my medical claims.

Name of Responsible Party:_____

Signature:_____ Date:_____