

Treatment Agreement

___ I consent to treatment compliance. I understand that non-compliance of my physician’s care/treatment plan may jeopardize health results.

Release of Information

___ For the purpose of payment, I consent to Complete Foot and Ankle Care of North Texas (CFAA) to releasing my private health information to insurance carriers and/or third party payors. For the purpose of treatment, I consent to CFAA to releasing my information and/or contacting my treating physicians/healthcare providers.

Acknowledgement of Receipt of Notice of Privacy Practices

___ I acknowledge that I was offered and/or provided a copy of the HIPPA Notice of Privacy Practices.

Patient Financial Policy

___ Please honor the CFAA Reschedule Notice Policy; there IS a charge for missed appointments without a 24 hour advanced notice.

Repeated missed/cancelled appointments and/or non-compliance may result in termination of care.

___ Your **insurance policy is a contract between you and your insurance company.** As a courtesy, CFAA will file insurance claims for you with an assignment of benefits. You agree to have your insurance company pay CFAA directly. If your insurance company does not pay CFAA within 60 days, you (patient or guardian of a minor patient), will be responsible for payment of services in full.

___ **You are responsible for understanding your insurance benefits, restrictions and limitations.** As a courtesy, CFAA will obtain and provide you with a benefit summary per our communication with your insurance company. However, you are fully responsible for all charges due to services rendered. You are encouraged to contact your insurance for clarification of benefits prior to services rendered.

___ You are responsible for obtaining authorizations/referrals needed to approve treatment under the care of CFAA. You must inform CFAA of all personal (home address, phone numbers, etc...) and/or insurance changes, including new policy info and authorization/referral requirements. **You are responsible for any charges denied due to not providing correct/current info.**

___ **All charges** (applicable co-pay/co-insurance/deductible/out of pocket/self pay/over the counter) **are due at the time of service.** We accept credit/debit (VISA, MasterCard, American Express and Discover), cash or check (make payable to CFAANT).

___ If CFAA is contracted with your insurance, charges will be calculated based on your insurance benefit/limits and our negotiated fee agreement with your carrier. You will be subject to “Out of Network” rates if CFAA is not contracted with your insurance.

___ CFAA does not file to secondary insurance unless the patient has Medicare. However, we will provide an itemized statement upon your request for you to bill your secondary insurance yourself. If you possess two insurance plans, you MUST notify us of your designated PRIMARY policy.

___ Pre-scheduled surgical procedure charges (applicable co-pay/co-insurance/deductible/out of pocket/self pay) are due in full no later than at the pre-operative appointment. For other services provided in the hospital, we will bill your health plan and/or you consecutively.

___ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Payment exceptions will be agreed upon in writing.

___ PAST DUE accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due CFAA.

___ Accounts not maintaining a good financial status will result in the termination of the CFAA of North Texas Doctor-Patient relationship.

___ There is a service fee of \$25.00 for all returned checks. Upon an Insufficient Funds (NSF) or CLOSED ACCOUNT occurrence, all future remittances must be paid in the form of cash, debit, credit or money order. Restitution of “Theft-by-Check” will be pursued through the District Attorney’s Office.

___ CFAA issues patient refund checks within 90 days of a completed investigation of the potential overpayment. Credits in the amount of \$10.00 or less will remain on the patient account for future purchase(s), except in the case of patient and/or physician care termination.

___ ONLY unopened, unused NON-custom items are returnable within 30 days of receipt. Custom items are subject to specified contract stipulations.

___ Financial matters should be discussed with the CFAA Front or Business office, **not the medical provider or nurse staff.**

Authorization of Payment

___ I hereby consent to assignment of medical benefits directly to CFAA for the payment of any services rendered. I also authorize release of medical records necessary to process my healthcare claims. I fully understand that in the event my insurance company does not pay for services I receive, I will be fully financially responsible for payment.

Medical Records Requests

___ Federal and State Law require records be processed within 30 days. Our office policy allows for 15 business days for common requests.

Records released to patients require a fee payment. However, requests for records to be released to a physician are free of charge.

Requests for records to insurance companies, attorneys, etc for disability and other situations will be charged/invoiced per Federal and State Law. All requests must be made in writing by the patient, legal guardian of a minor child and/or medical power of attorney.

CFAA is committed to providing the best possible care and service to you with professionalism and integrity. We regard your complete understanding of our policies as essential to your care/treatment. Please discuss your questions/concerns with our front office staff.

Patient’s Name: _____ **Signature of Patient/Guardian:** _____ **Date:** _____

CFAA Staff Witness: _____ **Date:** _____ **Patient initials to indicate copy received:** _____