ORANGE COUNTY
FOOT & ANKLE GROUP

FINANCIAL FORM - Please choose one of the following financial options

We are committed to providing you with the best possible care. If you have insurance, we would be pleased to assist you in receiving your maximum allowable benefits. To achieve these goals we need your assistance and understanding of your financial arrangement with our office.

Our Staff will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however:

- Your insurance is a contract between you, your employer, and your insurance company.
- The insurance coverage you will receive depends on the quality of the plan purchased by you or your employer. Plans vary greatly and insurance companies do not give us the exact reimbursement amounts. Please contact your insurance company if you need an exact reimbursement amount.
- While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

( ) I will be paying the FULL AMOUNT of my appointment at the time of service by one of the following: CASH, CHECK, CREDIT CARD or 3rd Party Financing. Orange County Foot & Ankle Group, Inc. will file my insurance on my behalf and will request the benefits be reimbursed to me if applicable.

( ) I authorize my insurance company to make payments directly to the medical office for benefits otherwise payable to me. I will be paying my estimated co-pay at the time of treatment and my credit card number will be kept on file. I hereby authorize Orange County Foot & Ankle Group, Inc. to keep my signature on file and to charge my credit card account for any and all treatment fees remaining after 45 days. A receipt will be mailed to me.

We will need a copy of your credit card on file:

Cardholder's Name

_____

Cardholder's Signature

_____

Cardholder's
Address_____City_____

State_____ Zip Code_____ ( ) MasterCard ( ) Visa ( ) AMEX ( ) Discover

Credit Card #
_____Exp_____CVC_____

Authorization:

I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I understand that a service charge of 1.75% a month (21% per annum) on the unpaid balance will be charged on accounts exceeding 45 days unless previous written financial arrangements have been made. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I agree to give at least 24 hour notice when needing to cancel or change an appointment. Not providing the notice will result in a charge of $50.00 for the appointment time.

Signature _____

Date_____