Insurance/ Payment Information

Your understanding of our financial policies is an essential element of your care and treatment.

Please Provide an Insurance Card: (if provided do not fill this space)

Primary Insurance Company Name: ____

Insured Name: ______________________ Date of Birth ____________ Contract # _____________
Group # _______

Secondary Insurance Company Name: ____

Insured Name: ______________________ Date of Birth ____________ Contract # _____________
Group # _______

Payment Options: Please mark one or more of your payment choice

- HSA/ Flex spending Card- Please provide the card
- Check- Payment in clinic or mail with statement
- Credit Card: Due to the increase of credit card fees there will be a **1% charge** to use any credit card or debit card. This will be added to your balance.
- Online Payment- Go to www.jacksonfootankle.com and make a payment online (1% convenience charge will be added)
- Cash- In office payment
- Bank Account Transfer- Email will sent to make a secure payment via QuickBooks

Sign up for the clinic Newsletter and online Statements and **get $5 your balance**

Would you like to sign up for it? **Please circle one**

Yes (email) _________ ____ NO

Statements:

How would you like to get your statements? **Please circle one**

Mail Electronic

We do not accept CareCredit

Please Turn the page

Offices in Adrian, Ann Arbor, Jackson (p) 517-879-4241
www.Jacksonfootankle.com (f) 517-879-4240

Insurance/ Payment Information

• As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE BY YOU, OR YOUR HEALTH INSURANCE CARRIER, PAYMENT FOR OFFICE SERVICES ARE DUE AT THE TIME OF SERVICE. WE WILL ACCEPT VISA, MASTERCARD, DISCOVER, OR CASH.

• YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. AS A COURTESY, WE WILL FILE YOUR INSURANCE CLAIM FOR YOU IF YOU ASSIGN THE BENEFITS TO THE DOCTOR. IN OTHER WORDS, YOU AGREE TO HAVE YOUR INSURANCE COMPANY PAY THE DOCTOR DIRECTLY. IF YOUR INSURANCE COMPANY DOES NOT PAY THE PRACTICE WITHIN A
REASONABLE PERIOD, WE WILL HAVE TO LOOK TO YOU FOR PAYMENT.

• WE HAVE MADE PRIOR ARRANGEMENTS WITH CERTAIN INSURERS AND OTHER HEALTH PLANS TO ACCEPT AN ASSIGNMENT OF BENEFITS. WE WILL BILL THOSE PLANS WITH WHICH WE HAVE AN AGREEMENT AND WILL ONLY REQUIRE YOU TO PAY THE CO-PAY/CO-INSURANCE/DEDUCTIBLE AT THE TIME OF SERVICE.

• IF YOU HAVE INSURANCE COVERAGE WITH A PLAN WITH WHICH WE DO NOT HAVE A PRIOR AGREEMENT, WE WILL PREPARE AND SEND THE CLAIM FOR YOU ON AN UNASSIGNED BASIS. THIS MEANS YOUR INSURER WILL SEND THE PAYMENT DIRECTLY TO YOU. THEREFORE, ALL CHARGES FOR YOUR CARE AND TREATMENT ARE DUE AT THE TIME OF SERVICE.

• CANCELATIONS: IF YOU HAVE TO CANCEL YOUR SCHEDULE VISIT PLEASE GIVE THE OFFICE 24 HR NOTICE. IF YOU FAIL TO GIVEN NOTICE OR JUST DON'T SHOW UP THERE WILL BE A $25 FEE CHARGED TO YOUR ACCOUNT.

• ALL HEALTH PLANS ARE NOT THE SAME AND DO NOT COVER THE SAME SERVICES. IN THE EVENT YOUR HEALTH PLAN DETERMINES A SERVICE TO BE "NOT COVERED," OR YOU DO NOT HAVE AN AUTHORIZATION, YOU WILL BE RESPONSIBLE FOR THE COMPLETE CHARGE. WE WILL ATTEMPT TO VERIFY BENEFITS FOR SOME SPECIALIZED SERVICES OR REFERRALS; HOWEVER, YOU REMAIN RESPONSIBLE FOR CHARGES TO ANY SERVICE RENDERED. PATIENTS ARE ENCOURAGED TO CONTACT THEIR PLANS FOR CLARIFICATION OF BENEFITS PRIOR TO SERVICES RENDERED.

• YOU MUST INFORM THE OFFICE OF ALL-INSURANCE CHANGES AND AUTHORIZATION/REFERRAL REQUIREMENTS. IN THE EVENT THE OFFICE IS NOT INFORMED, YOU WILL BE RESPONSIBLE FOR ANY CHARGES DENIED.

• THERE ARE CERTAIN ELECTIVE SURGICAL PROCEDURES FOR WHICH WE REQUIRE PRE-PAYMENT. YOU WILL BE INFORMED IN ADVANCE IF YOUR PROCEDURE IS ONE OF THOSE. IN THAT EVENT, PAYMENT WILL BE DUE ONE WEEK PRIOR TO THE SURGERY.

• PAST DUE ACCOUNTS ARE SUBJECT TO COLLECTION PROCEEDINGS. ALL COSTS INCURRED INCLUDING, BUT NOT LIMITED TO, COLLECTION FEES, ATTORNEY FEES AND COURT FEES SHALL BE YOUR RESPONSIBILITY IN ADDITION TO THE BALANCE DUE THIS OFFICE.

• EVERY STATEMENT AFTER THE FIRST WILL BE SUBJECT A $5 STATEMENT FEE WHICH WILL BE ADDED TO THE BALANCE

SIGNATURE OF PATIENT/RESPONSIBLE PARTY: ____

PRINTED NAME OF PATIENT/RESPONSIBLE PARTY: ____

DATE: _________________

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