

Patient Financial Agreement Regarding Payment of Accounts

• 6355 Walker Lane, Suite 503, Alexandria, VA 22310 • 703-822-0895 • Fax: 703-822-0899 •

Non-Participating Insurance Plans – I understand that payment for medical services must be made at the time of service. Unless special arrangements have been made, I understand that Dr. Adamson does not file insurance claims for non-participating insurance companies. **Patient Initials:_____.**

Participation Insurance Plans – Insurance claims will be filed for your office visits and surgery but you are still responsible for co-payments, deductibles and unallowable charges not paid by your insurance carrier.

*** I understand that it is my responsibility to see that the doctor is paid. My insurance coverage is a contract between me (the patient) and the insurance company, not the doctor and the insurance company.** **Patient Initials:_____.**

*** I understand that once billed, my insurance company is allowed 45 days for the balance to be paid. If my insurance carrier does not pay the claim within 45 days, I will be responsible for the balance in full. Any payments made by your insurance carrier thereafter will be promptly refunded to you.**

Patient Initials:_____.

*** HMO/PPO claim denials due to cancellation of policy, lack of referral, lack of authorization or reversals of authorizations are the patient's responsibility regardless if previously obtained.** I understand that Dr. Adamson's office staff will try to advise and assist me in referral/precertification procedures. I understand that final responsibility lies with me, the patient, to comply with my specific insurance requirements. **Any referrals must be presented to our business office before seeing the doctor.**

Patient Initials:_____.

*** I understand that I will be charged a \$35 missed appointment fee if I do not cancel my appointment 24 hours in advance.**

Patient Initials:_____.

Delinquent and Past Due Accounts

If you expect to be late with a payment, please contact our office. Accounts, which are not paid on time, may be turned over to a collection agency.

I understand I will be charged \$35.00 for all returned checks. **Patient Initials:_____.**

I understand that my information will be registered with the credit bureau if I am turned over to collections. I also understand that I will be responsible for all collection and attorney fees in the amount of 33 1/3% plus filing cost/processing fees.

Patient Initials:_____.

Privacy Policies: We treat all of your "Protected Health Information" (PHI) with strict confidentiality. Our employees and vendors are required to follow the guidelines included in the HIPPA Privacy Act of 1996. My signature below gives permission for A.A. Podiatry, P.L.L.C. to use and disclose the required PHI to carry out the treatment, payment or other healthcare operations of the practice.

By my signature below, I acknowledge receipt of a copy of A.A. Podiatry's Patient Financial Agreement and agree to its terms. I also give permission for medical and/or surgical treatment by the Doctors of A.A. Podiatry, P.L.L.C.

Signature: _____

Date: _____

Printed Name: _____