FOUNDATION
FOOT & ANKLE CENTER

Please review the following policies for our facility. Occasional updates to these policies may occur.

CANCELLATIONS:
We require 24-hour notice if you need to cancel or reschedule your appointment. You may be charged with a fee of $25, if you do not show for your appointment without any notification. Repeated failure to keep your appointments may result in a dismissal from our medical service.

NO SHOW POLICY:
No shows are an inconvenience to patients who need access to medical care in a timely manner. Therefore, we charge $25 for missed appointments.

LATE POLICY:
Patients arriving more than 15 minutes late may be asked to reschedule.

AFTER-HOURS PHONE CALLS:
For any concerns and questions, please leave a message at our office, 630-635-5889.
For any immediate post-surgical questions, please contact the doctor via information provided to you during the preoperative consultation.

EMERGENCIES:
For any life-threatening emergency, please call 911 or go directly to the local emergency room.
During clinic hours, urgent medical issues will be seen and treated promptly. This may mean a disruption in your scheduled appointment. Emergent circumstances will require immediate attention.

CONSENT FOR TREATMENT:
We strive to provide you with the highest standard of medical care. When our doctors are treating you, you are consenting to the treatment provided by Foundation Foot and Ankle Center and its employees. You are authorizing the physical health care services deemed necessary or advisable by our doctors. Possible benefits, complications, risks will be discussed with you. Please ask any questions you may have. No guarantee or assurance will be made as to the therapeutic results that may be achieved. You have the right to refuse any treatment at any given time, and you must notify the doctor, if you wish to decline or refuse any treatment.

BILLING AND INSURANCE:
We are contracted with various insurance companies and will bill them directly. Any remaining balance will be billed to you. Please bring your insurance card to each visit to ensure we bill your insurance correctly. If you have coverage through a non-contracted insurance plan, we will provide you with a coded bill to submit to your insurance company. It is your responsibility to follow up with your insurance company and pay the bill in a timely manner. The insurance companies that we are contracted with may change from time to time. If you are considering a new insurance plan, please call our clinic to check if we are contracted with that plan. You are responsible for the charges at the time of the visit. When a patient turns 18 years old, they become the guarantors of their account. They will be asked to review their own financial agreements the first time they have a visit after turning 18.

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FINANCIAL INTEREST STATEMENT:
Foundation Foot and Ankle Center is a locally owned company that has a financial interest in the ancillary services provided in our clinic, such as diagnostic services, or specialty care. You always have the option to use an alternate facility for services ordered. You will not be treated differently if you choose to do so. We will try our best to provide you with a list of appropriate alternative facilities if you want to receive services elsewhere.

PAYMENT AND FEES:
We request payment at time of service for co-pays and private pay. Private pay patients receive a discount when fees are paid on the day of the service. If you are having financial difficulty, please contact our office to establish a payment plan. Repeated failure to pay may result in dismissal from Foundation Foot and Ankle Center and assignment of your account to a collection agency in the event of non-payment. A rebilling fee / finance charge may be applied to any overdue balance, authorized by Illinois State Law.

MEDICAL RECORDS REQUESTS:
There will be a fee for handling and preparing medical records requests from any party other than the patient's health insurance company and other medical professionals. Any record more than 5 pages will be charged with additional $0.25 dollars per additional page. This fee must be paid prior to the release of the records. An additional $5 will be charged for copies of x-ray in a photo format. A medical record release form is required to be signed before records can be released.

MEDICAL PAPERWORK REQUESTS:
If you have any work forms (FMLA, disability, etc) that needs to be filled out, please bring the forms to the office or have it faxed to the office. Please allow up to a week prior to completing the paperwork. Please be mindful of when you need your paperwork completed by and bring it in within an appropriate timeframe. It is not our responsibility if we do not fill out your paperwork intime, if you do not provide it within an appropriate timeframe.

Please make checks payable to: "Foundation Foot and Ankle Center". If your check is returned for non-sufficient funds, we will add a service charge to your account. If that happens, you will be asked to pay the amount of the check plus the service charge of $40 in cash within 10 day. If your account has not been paid in full by then, it may be referred for collection action.

Some insurance plans do not cover certain procedures, such as certain treatment injections, custom orthosis, and certain cosmetic procedures. In such cases, you will be asked to sign a waiver agreeing to pay for the visit prior to our doctors rendering treatment(s). Please call your insurance company to determine coverage for a procedure that is being considered.

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ACKNOWLEDGEMENT

I fully read and understand the information and authorization noted on this form. I authorize my insurance benefits to be paid directly to the health care provider. **I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collection of any amounts owed on this visit or future visits, I agree to pay for all costs, including attorney fees.** I authorize the health care

provider or insurance company to release any information required for the claims associated with the clinic visit. I hereby authorize the physician to conduct examinations, perform procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I also understand I may revoke the privilege listed in this form at any times by submitting my request in writing to this office.

MEDICARE: I understand my medical provider agrees to accept the Medicare allowed charge as the full charge, and I am only responsible for the deductible, co-insurance and non-covered services.

This agreement and authorization form will be valid for a period of 365 days from the date of my signature below unless revoked by me in writing sooner or restricted to a shorter time by applicable law.

I have read this entire form and any questions I had about this form have been answered to my satisfaction. I understand and agree to its contents.

Print Name: _____ **Date:** _____

_____

Signature of Patient or Patient's Representative **Relationship**