Consent For Care And Treatment

Freel Foot &
Ankle Clinic, PC
3740 Eastlake Centre
Quincy, IL 62301

Excellence in Motion

I, the undersigned, do hereby agree to give my consent for the *Freel Foot & Ankle Clinic* to furnish medical care and treatment to ____ considered necessary and proper in diagnosing or treating his/her condition.

Patient/Guardian ____ Date _________________________

Benefit Assignment And Release Of Information

I, the undersigned, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and third party insurance payors to the *Freel Foot & Ankle Clinic*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian ____ Date _________________________

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money to be refunded to your insurance company if you have already received this money in refund from the Freel Foot & Ankle Clinic. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed to us, you recognize an obligation to promptly remit same to the *Freel Foot & Ankle Clinic*.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS: ____

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Estimated patient payment ____

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Arrangements for payment of patient's share ____

NOTE: Estimated coverage information is provided as a courtesy to our patients but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party ________________________________ Date _____________________

Center Representative/Witness ___________________________________ Date _____________________