Foot And Ankle
Specialists of Tennessee

8870 Cedar Springs Lane
Suite 104
Knoxville, TN 37923
865-686-8486

PATIENT FINANCIAL AGREEMENT

Financial Agreement
Thank you for choosing us as your trusted foot and ankle specialist. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have created this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

I acknowledge, that as a courtesy, Foot and Ankle Specialists of Tennessee PLLC may bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand there is a fee for returned checks.

Third Party Collection
I acknowledge Foot and Ankle Specialists of Tennessee PLLC may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits
I hereby assign to, Foot and Ankle Specialists of Tennessee PLLC any insurance or other third-party benefits available for health care services provided to me. I understand Foot and Ankle Specialists of Tennessee PLLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Foot and Ankle Specialists of Tennessee PLLC, I agree to forward all health insurance or third-party payments that I receive for services rendered by Foot and Ankle Specialists of Tennessee PLLC to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit
I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Foot and Ankle Specialists of Tennessee PLLC by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications
I agree that, in order for Foot and Ankle Specialists of Tennessee PLLC or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that, Foot and Ankle Specialists of Tennessee PLLC or EBO Servicer and collection agents, may contact me by telephone at any telephone number,

without limitation of wireless, I have provided or, Foot and Ankle Specialists of Tennessee PLLC or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. A photocopy of this consent shall be considered as valid as the original.

Patient Obligation to Balance
I acknowledge that any balance has to be paid in full prior to having any elective, optional, cosmetic, or non-medically necessary type of procedure, operation, or surgery. I agree to pay any outstanding balance within 90 days from date of service unless a payment plan has been established.

Insurance
We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Copayments and Deductibles
All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered Services
Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of Insurance
All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage Changes
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company

does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment
Patients who do not make payment arrangements risk being dismissed from the practice. Foot and Ankle Specialists of Tennessee PLLC reserves the right to dismiss patients for delinquent financial accounts on personal balances. If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. If dismissed by one of our providers due to a delinquent financial account, you will not be able to establish care with or continue seeing any other providers at Foot and Ankle Specialists of Tennessee PLLC. If dismissed, medical care will not be withheld for a medical emergency for thirty days from the date of dismissal.

Late Patient, No Show, and Cancelation Policy Attestation
We understand that there may be times when an appointment just does not work due to emergencies, obligations or unforeseen circumstances. Unfortunately this can have a large negative effect on our clinic schedule and take away from the time our specialists have to spend with each patient. In an effort to be as transparent as we can be, if you are more than 1 hour late to your appointment, do not come to your appointment. If we are not made aware of an appointment cancellation at least 24 hours in advance, you may be charged a twenty-five dollar ($25) fee, which is not covered by insurance. Our clinic will also provide a one-time fee waiver if the appointment is rescheduled within a week's time. Appointments missed by more than 15 minutes without advanced notice are also subject to rescheduling depending on availability. Please help us to better serve you by keeping your regularly scheduled appointment and communicating with us if you cannot make your appointment time.

PCI Compliance
PCI compliance is compliance with The Payment Card Industry Data Security Standard (PCI DSS). Our practice utilizes PCI security to protect and encrypt your credit card and other payment information. By signing this notice, you agree to allow our practice to securely store your information on file for billing purposes.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for reading and understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial agreement and agree to abide by its guidelines.

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Signature of Patient or Responsible Party Printed Name Date