FINANCIAL POLICY

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.

Highpoint FOOT & ANKLE Center
For every Season of your Life.

Acknowledgement of Financial Policy

Please be advised that you, the patient, are responsible for any procedures or office visits that are not covered by the insurance company.

We will submit all office visits and procedures to participating insurance companies.Certain procedures do need authorization. Please be aware that authorization does not guarantee payment.

I have read the above policy and I am aware that I am responsible for paying any balance on my account in a timely manner. Accounts that are not paid within 90 days may be sent to a collection agency. There will be a 15% charge added to your account for any collection or legal fees.

There will be a $1.00 service charge for all credit card transactions.

_____
Patient Name (Please Print)

X_____ Date: _____
Signature of Patient (or parent, if minor)