

### Insurance Benefits

- ▶ I understand that I am responsible for understanding my insurance benefits
- ▶ I understand that Chicago Podiatric Surgeons is not responsible for providing my benefit information to me, and that any information given to me is not a guarantee of benefits.

### Insurance Submission

- ▶ Chicago Podiatric Surgeons will submit all claims to **Primary carriers**.
- ▶ Chicago Podiatric Surgeons will submit to **Secondary carriers** for Medicare patients only.

### Patient Balances

- ▶ **Chicago Podiatric Surgeons will ask for a copy of a major credit card to keep on file in a secure server. I authorize Chicago Podiatric Surgeons to charge my cc on file with any unpaid balances that are greater than 60 days old.**
- ▶ Chicago Podiatric Surgeons will send monthly statements to all patients with current balances
- ▶ As a Chicago Podiatric Surgeons patient, I understand that I am responsible for payment of medical services.

- I authorize Chicago Podiatric Surgeons to submit insurance claims on my behalf, and to accept payment of medical benefits for services rendered.
- I authorize Chicago Podiatric Surgeons to initiate a complaint to my Insurance Company, and/or Insurance Commissioner on my behalf.
- I authorize the release of medical information to my Insurance Company, adjuster, or attorney involved in the processing of my claims.
- In the event that my Insurance Company remits payment to Chicago Podiatric Surgeons with a check made out in my name, I authorize Chicago Podiatric Surgeons to deposit that payment and credit my account accordingly.
- I understand that although Chicago Podiatric Surgeons accepts Medicare and certain PPO/HMO assignments, I am responsible for any co-payment, co-insurance, deductible, and non-covered services.

- ▶ I understand that there will be a \$30.00 service charge for returned or bounced checks
- ▶ I understand that if my account is turned over to an outside collection agency, my balance will be increased by 33% to cover the cost of the collection agency's fee.
- ▶ I understand that there will be a \$25.00 charge for missed or cancelled appointments unless I give a 24-hour notice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

*Thank you for choosing Chicago Podiatric Surgeons as your healthcare provider.*