EMERALD COAST
FOOT AND ANKLE CENTER

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

info@ecfootankle.com
P: (850) 660-7778
F: (850) 203-4093

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Financial Policy

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please read each line to ensure you understand our policies:

NO SHOW: 24 hours notice is required for cancellation of your appointment. **Failure to provide 24 hours notice of cancellation will incur a $50 fee**. If you fail to provide cancellation notice on 2 separate occasions, you will have to discontinue care with our providers.

COPAYMENTS: It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

DEDUCTIBLES & CO-INSURANCE: If you have not met your deductible, we may collect a **$125** deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

SELF-PAY PATIENTS: Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.

REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

SURGERY CANCELLATION: Failure to provide **5 business days** notice of cancellation prior to scheduled surgery date will incur a **$500** fee.

BALANCES/COLLECTION FEES: If balance is not collected within 30 days from the postmark date of a mailed statement, a **$12** late fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a **$35** administrative fee will be added. We accept cash, checks, all major credit cards and for convenience, payments can be made securely through the NextGen Patient Portal.

FMLA/DISABILITY/MEDICAL RECORDS: There is a **$40** charge for completion of these forms. There is a **$10** fee to obtain a copy of your medical records. However, your medical records can be obtained for free online via the NextGen Patient Portal.

I have read and understand these financial policies.

Patient Name (print):_____

Patient/Responsible Party Signature:_____ **Date:**_____

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