

**Advanced Podiatry of Hampton Roads
Rex G. Diaz, DPM, FACFAS**

Authorization and Financial Information

We at Advanced Podiatry of Hampton Roads strongly feel that all patients deserve the very best medical care that we can provide. Everyone benefits when definitive financial arrangements are agreed upon. Our professional services are rendered to you, not the insurance company. Therefore, payment for these services is your responsibility.

PLEASE READ AND SIGN THE FOLLOWING:

1. I authorize this office to release any information necessary to expedite claims.
2. I authorize this office to bill my insurance company for medical services with payment made directly to the physician.
3. In the event I receive payment from my insurance carrier, I agree to endorse payment I receive over to the physician.
4. I understand and agree to pay the physician's charge for any missed or cancelled appointment when 24-hour notice is not given. The charges are:

\$40.00	"No Show" for missed regular appointments
\$100.00	Missed History & Physical appointment
\$100.00	Missed biomechanical exam and casting for footwear
\$200.00-\$400.00	Missed surgery appointment
\$25.00	Checks returned for insufficient funds
\$35.00	Collection Agency Fee

I understand and agree that I am directly and fully responsible to Advanced Podiatry of Hampton Roads for payment of all charges. I understand and agree that if my insurance company fails to pay my balance in full or payment is not made within 60 days, it is my responsibility to pay the physician's bill.

If patient/guarantor defaults to any terms and this account is referred to a collection agency, then the patient and/or guarantor promise to pay all associated costs including collection fees of \$35.00. I do further agree to pay interest on the unpaid balance from the date said monies become due and payable.

Name of Patient: _____

Responsible Party: _____
SELF/PARENT/GUARDIAN (circle on)

Signature of Responsible Party: _____ Date: _____

Witness: _____ Date: _____

-----Internal Use Only-----

*****Refusal to sign Financial Agreement does NOT exempt patient from responsibility*****

If patient representative refuses to sign acknowledgement please document date and time notice was presented to patient and sign below.

Presented (date and time): _____

By (name and title): _____