

Family Foot Care & Surgery, LLC
309 Seaside Avenue Suite 202
Milford, CT 06460

Patient Name _____

Payment is expected at the time of treatment for any known out of pocket expenses including deductibles, co-pays, co-insurance, and/or non-covered services or supplies. For any services not paid at the time of my visit, I request that payment of benefits be made on my behalf directly to the Provider for any services furnished to me by the provider. I authorize the release of any medical record information necessary to process these claims. This assignment will remain in effect until revoked by me in writing. Any amounts denied for any reason by your insurance carrier not known to us are due at the time of claim processing.

Please understand that the exact determination of benefits occurs at the time your insurance company processes and pays the claim. Every effort will be made to notify you should a difference occur between what was expected and what was actually paid. You should also receive notification directly from your insurance carrier concerning the benefits paid from your visit.

We understand that your insurance coverage is very important. You are responsible for knowing the benefits, limitations, deductibles, and/or restrictions that your policy may stipulate. We will facilitate the bill payment process to our best abilities. In order to avoid any misunderstanding, we ask that you confirm your benefits with your insurance carrier.

I also understand and agree that the responsibility for obtaining referrals/authorizations for in network treatment is solely mine. I understand that I will be seen as an out-of-pocket network patient if I do not obtain the appropriate referral for treatment it will then be my responsibility for all unpaid benefits.

I understand the financial policy and responsibility for my account.

Patient/Responsible Party's Signature

Date