**FINANCIAL POLICY**

Thank you for choosing our office to provide your medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

**AUTHORIZATION FOR MEDICAL TREATMENT**

You authorize Dr. Sudberry to conduct and direct your medical care. You also authorize the staff, as directed by the physician, to dispense medications, perform diagnostic procedures and provide other care, which in the judgment of the doctor, is required for treatment.

**ASSIGNMENT OF BENEFITS**

You agree that you have coverage with your insurance as presented and assign directly to Tennessee Foot & Ankle Specialists, P.C. all insurance benefits payable for services rendered. You understand that you are responsible for payment of copayments, coinsurance, deductibles, and non-covered services. You authorize the doctor to release all information necessary to secure payment of benefits. You also authorize release of medical information to your insurance carrier or requested physician to provide continuity of care.

**PATIENT BILLING**

You guarantee payment of all charges for services provided. In the event that the patient or guarantor fails to comply, each consents to the disclosure of necessary information to a collection agency or attorney. This disclosure will not be deemed as a breach of patient confidentiality by the physician. All fees for the use of the collection agency in collecting any unpaid balanced will be the responsibility of the patient.

If any checks written by the patient/guarantor for services rendered are returned by the financial institution for insufficient funds, there will be a fee of $29.00.

**ORTHOTICS POLICY**

If custom orthotics are prescribed, and you wish to proceed, a $100 deposit is required for orthotics casting/scanning. Any overpayment will be refunded to the patient.

**APPOINTMENT CANCELLATION POLICY**

After 2 missed appointments without 24 hour notice, a $20 cancellation fee will apply for any future missed appointments, unless the appropriate 24 hour notice is given.

**PRIVACY STATEMENT**

Any information disclosed in your records will remain confidential and will not be used for any other purpose except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

In signing below, you acknowledge that you have read & understand the attached Notice of Privacy Practices. If you would like a copy, please request it from the front desk.

**RELEASE OF INFORMATION**

If you would like someone other than yourself (ex. spouse or family member) to be able to obtain information about appointments, billing, or medical records, please list their name below.

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Name Relationship to patient

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Name Relationship to patient

**In signing below, you acknowledge that you have read and understand the above financial policy, notice of privacy practices, and release of information.**

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Patient Name (please print) Parent, Guardian, or Representative

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Signature Date