



**Sarasota Foot Care Center, PA
1921 Waldemere Street, Suite 106
Sarasota, FL 34239**

Welcome to the office of Sarasota Foot Care Center, PA. Our Front Desk and Billing staff will be happy to assist you in answering any further questions you may have regarding this information.

MANAGED CARE (HMO/PPO/POS/EPO) If we participate with your insurance, you are responsible for paying your co-payment and for obtaining any referrals/authorizations your plan may require at the time of service. We will verify your insurance and benefits. If your deductible has not been met, you will be responsible for payment at the time of service.

MEDICARE PATIENTS -- We accept assignment on all Medicare claims. As a courtesy we will also file your secondary insurance. If we have to file your secondary more than twice or have excessive difficulty collecting the secondary balance, that balance will be billed to you. We do not file tertiary insurance policies.

NO FAULT/WORKERS COMP -- You must provide us with all necessary information to file your claims. Patients must have prior approval before being seen in this office. This is the patient's responsibility to obtain.

MEDICAID: We do not participate with Medicaid. Payment in full is expected at time of service, unless prior arrangements have been made.

SELF-PAY PATIENTS -- If you are uninsured, you are responsible for payment in full at the time of service, unless prior arrangements have been made with our Business Office at (941) 917-6232, Monday-Friday.

We accept cash, checks, MasterCard and Visa.

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. It is customary to pay for services when rendered unless prior arrangements have been made.

I have read and/or have been advised to read the entire Financial Policy outlined above:

Guarantor _____ Date _____

Patient Name _____
(Please Print)

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS:

I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I hereby authorize my physician to release any information regarding my medical condition, including disability or employment related information concerning my claims for my insurance carrier(s), authorized agent(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expense. I understand that my authorized representative or I may receive a copy of this authorization request. I also authorize direct payment of benefits to my attending physician.

Guarantor/Patient _____ Date _____

Signature of person responsible for payment _____

Date _____

