Patient Financial Responsibility

Welcome to Ashton Podiatry Associates! Realizing that financial surprises can be unpleasant, we wish to provide you with the following information concerning your financial responsibility for the services that you receive from Ashton Podiatry Associates.

If your insurance policy requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain that referral. Failure to obtain a required referral may result in denial of payment by your insurance company, in which case you would be responsible for payment of those charges. We are happy to assist you in obtaining referrals, however, the responsibility is ultimately yours.

Payment is requested at the time of service for any amounts which will be applied to copay, deductible or coinsurance. In addition, some services or supplies may not be covered by your insurance. Payment for these items will be requested at the time of service.

We will do our best to obtain accurate benefit information from your insurance carrier. However, we are sometimes given incorrect information by insurance companies, especially regarding such services as custom-casted foot orthotics, routine foot care and durable medical equipment. Any services denied by your insurance carrier will be your responsibility. You may also want to call your insurance company to understand your benefits.

Please inform us of any insurance changes. Failure to provide current insurance information may result in a denial of claims which could then become your responsibility. Please keep in mind that many insurance carriers have a claim filing deadline, sometimes as short as 60 days.

ASSIGNMENT OF BENEFITS & CONSENT TO RELEASE INFORMATION

Name of Beneficiary (Patient)_____
HIC or ID Number_____
I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Ashton Podiatry Associates, PA, for any services furnished me by Ashton Podiatry Associates, PA. I authorize any holder of medical information about me to release to my insurance carrier or to the Centers for Medicare Services (CMS) or its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. For all managed care plans (HMO, PPO, POS, EPO or other), I understand that I will be responsible for the copay, deductible and coinsurance as governed by the managed care contract, as well as for any services deemed non-covered.

Beneficiary (Patient) Signature_____
Date_____

Providing quality medical care for our patients is our primary concern.
Thank you for putting your feet in our hands!