

Fisher Foot & Ankle

1124 North Tennessee St, Ste 104 Cartersville, GA 30120
phone: 770-386-4111 fax: 770-386-4905 fisherfoot.com

Patient Financial Policy

We would like to thank you for choosing Fisher Foot & Ankle to provide care for you and will do our best to assure that you receive competent caring service. Please allow us to explain our office policies. If you have any questions, please ask.

Payment of Fees

Payment of fees that you are responsible for is required at the time of service unless prior arrangements have been made. We accept cash, checks, discover, mastercard, and visa. There will be a \$20 fee for returned checks. If you have had a check returned for insufficient funds you will be required to pay with cash or credit card in the future.

Insurance Claims

We file insurance claims as a courtesy to you, if you reassign your benefits to Fisher Foot & Ankle. However, you must pay your portion at the time of service and are responsible for any services not covered by your insurance. We will only bill plans with which we participate with. If you have a plan we do not participate with, you will be required to pay the entire bill at the time of service and the insurer will send the payment directly to you when you send in your claim.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS.

Appointment Scheduling/No-show Policy

We ask that you give us at least 24 hours notice before canceling or rescheduling an appointment so that another patient who needs care may be seen. There will be a \$25 charge for patients who do not call ahead of time to cancel or change their appointments.

Authorization to Release Information

In order to file insurance claims it is necessary to release information to the insurance company regarding examination and treatment.

Signature

I have read the policy and agree to the release of information as necessary regarding my treatment. I agree to assign benefits to Fisher Foot & Ankle, PC, so that insurance claims may be filed on my behalf. I also acknowledge my financial responsibility for copayments, deductibles, and non-covered services.

Signature of Responsible Party

Date