FOOT AND ANKLE SPECIALISTS

Dr. Cary L. Copeland - Dr. Dominic A. Rizzo - Dr. Renee L. Ash

The patient or guardian is responsible for the account regardless of insurance coverage. If your insurance is not paying your bill it is your responsibility to find out why. We do follow up your account and make every effort to get it paid.

In order to keep our fees down; payment is required at each office visit. Patients who are members of approved managed care plans are expected to pay their co-payments at the time of the office visit. We accept assignment only from those insurance companies that we are contracted with. Please remember we will make every attempt to collect payment from your insurance company. It is your responsibility to know your policy and you will be responsible for any charges after insurance has made payment, and adjustments are made.

The patient is responsible for payment of health care regardless of the status of his/her claim. Rejection of your claim by your insurance company does not relieve you of the financial obligation incurred for medical services rendered. It is your responsibility to pay any deductible amount, copay, or other balance not covered by your insurance. Many insurance plans appear much simpler than they actually are. You should review your coverage prior to visiting our office. We do our best to make you aware of what is or is not covered by your insurance but with so may plans we do not accept responsibility of unpaid claims. Know your plan.

Cancellation of an office visit must be made at least 24 hours in advance or you may be charged. "No Shows" will also be charged. We do, as a** courtesy **to our patients, try to call at least the day before to confirm your appointment.

Patient Name _____ Birth Date _____ Patient/Guardian Signature/Date _____

For New Patients:

I authorize the release of all medical records including information concerning HIV testing and the treatment of AIDS, AIDS related conditions, drug or alcohol abuse, drug related conditions and/or psychiatric psychological conditions:

Patient Signature _____ Birth Date _____

From: _____

Doctor's Name _____ Phone Number _____

Address _____

To: Dr. Cary L. Copeland, Dr. Dominic A. Rizzo or Dr. Renee L. Ash
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