

Financial Acknowledgement and Agreement - New Patient Form

Patients who carry health insurance should remember that professional services are rendered and charged to the patient and not the insurance companies. Your insurance is a personal contract between you and your insurance company. If you would like us to file your claim for you, please provide your card to the receptionist. Without your card or proof of insurance, your claims cannot be filed. **Payment is due in full on the date of service**, unless other arrangements have been made or we have a contract stating otherwise with your insurance company. We accept cash, check, Visa, Master Card, and American Express.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered.

Date _____
Signature of Responsible Party

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Bosa Medical Company (Dba: Ledesma Foot & Ankle). I also authorize the release of any medical or other information necessary to process a claim. To submit a claim to your insurance carrier, there must be complete patient and insurance information on file.

Date _____
Signature of Responsible Party

HIPAA Acknowledgement

I have been presented with a copy of the Centers Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information.

Date _____
Signature of Patient

If not signed by the patient, please indicate relationship to patient. _____

Signature _____ Date _____

