

## DFW FOOT AND ANKLE INSURANCE/PAYMENT AGREEMENT

Primary Insurance Company \_\_\_\_\_

POLICY/ID Number \_\_\_\_\_ Group/Acct Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Co-payment (Specialist) \$\_\_\_\_\_

**\*\*DFW Foot and Ankle does not file to secondary insurance unless the primary policy automatically forwards it to the secondary policy \*\***

**\*\*\*\* CASH PAY patients- full payment is due at the time of service. \*\*\*\***

### Payment Policy

**Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we will collect a portion of the office visit and submit claim to insurance. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable 60 days after the date of service. These periods allows sufficient time to process insurance and make payment of any remaining balance. This office's policy on payment plans will be discussed upon request. **Any appointment or walk-in visit to see the doctor will result in an office visit charge to your individual insurance company.**

### **Assignment to Pay Insurance Benefits**

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to DFW Foot and Ankle. This assignment is for services rendered to me by **DFW Foot and Ankle, Dr. Davey Suh.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment.

Signature _____	Date _____
Parent/Guardian	

I verify that the above information is correct and that I have supplied a current insurance card for filing medical services rendered to me. I also agree to update this form with any changes as they occur. I understand that failure to notify DFW Foot and Ankle of any changes or insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and DFW Foot and Ankle.

Signature _____	Date _____
(Parent/Guardian)	