1703 Polaris Circle | Ottawa, IL 61350

CROWHURST
FOOTCARE

815 434 1900 | CrowhurstFootcare.com

CANCELLATION AND FINANCIAL POLICIES

OFFICE VISITS:

There will be a $50.00 charge for EVERY appointment you do not call or do not show. You MUST notify the office **24 HOURS PRIOR TO** your appointment date to cancel or reschedule your appointment to avoid any fees. If there are 3 or more appointments that are missed without a 24 hour notice we will be forced to dismiss you from the practice.

PROCEDURES:

There will be a $100 charge for any missed procedures. Please notify the office **48 hours PRIOR TO** your scheduled procedure date to cancel or reschedule to avoid any fees.

COLLECTION ACCOUNTS:

If your account should go to our collection attorney there will be an **additional charge of 35%** added to your overdue balance that is the fee charged by our collection attorney.

RECORDS:

The first copies of your medical records are free. You will need to sign a medical records release form to receive them. Additional copies will be charged a fee allowed by the State of Illinois.

There is a $10.00 fee for ALL FLMA AND DISABILITY Paperwork That Needs To Be Filled Out By The Doctor.

I, _____, understand that the above cancellation, collection account and records fees will not be covered by my insurance and I will be solely responsible for payment. Any balance after 90 days on your account will be sent to our Attorney and reported to the credit bureau.

I agree to sign any and all required forms, including any and all forms mandated by the Health Insurance Portability and Accountability Act (HIPAA), to release information and expedite the payment of my medical bill from services rendered by the doctor(s). If I have medical insurance benefits, I authorize the doctor(s) to submit a claim or claims on my behalf to my insurance company, however I shall remain responsible for the processing of my claim or claims to my insurance company and I hold harmless the doctor(s) in this regard. I agree to pay in full my medical bill. If my medical insurance benefits do not pay my medical bill in full, then I will pay any balance due upon request of the doctor(s) by the date specified by the doctor(s). If I fail to pay said medical bill in full by the due date then I will pay all costs, court costs, collection fees, and attorney's fees incurred by the doctor(s) in collecting the amount due.

I have read, understand, and agree to this AGREEMENT TO PAY on;

_____ _____

DATE AND YEAR RESPONSIBLE PARTY SIGNATURE