The Ankle and Foot Center of Fox Valley, Ltd
376 S. Route 59 Suite 108
Naperville, IL 60540
Phone: 630-778-7670 Fax: 630-778-7671
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Nancy A. Jagodzinki, D.P.M

Office Financial Policy

I. As a courtesy, we will file to your primary and secondary insurance. It is your responsibility to make sure that insurance company has the most recent address and contact information.
II. W are requried to make of copy of your insurance card for verification purposes. It is your responsibility to notify our office if there have been changes to your insurance.
III. We will collect your deductible, co-payment, and uncovered service fees at the time of service. Accepted payment methods are: Cash, Check, MasterCard, Visa, and Discover Card.
IV. Your insurance will send you an explanation of benefits that explains what they have paid to our office and what your responsibility is.
V. There is a $25.00 charge on all returned checks.
VI. If payment is not received within 30 days of filing date with your insurance, you will be notified that payment is due.
VII. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file to your insurance for you. If you have any questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside of this office.

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENTS AND AUTHORIZATIONS TO RELEASE INFORMATION

I. RELEASE OF INFORMATION- "I, the below named patient, do hereby authorize any physician examining and/ or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Cross Blue Shield of IL or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/ or diagnosis."
II. PHYSICIAN INSURANCE ASSIGNMENT- "I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/ or individual surgical and/ or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services."
III. MEDICARE - Patient's certification authorization to release information and payment request. "I certify that the information given by me applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize the holder of medical or other information about me to release Social Security Administration/ Division of Family Services or its intermediaries or carry any information needed for this of a related Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me."
IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember the insurance is considered a method of reimbursing the patient of fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allows for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible, co-insurance, or any other balance not paid for by the insurance or third payer within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and or/ suit, the prevailing party shall be entitled to reasonable attorney fee's and costs of collection.

Signature of Patient or Legal Guardian: ____

Print Name of Patient or Legal Guardian: ____

Patient Name: ______________________________ Date: ______________________