erie Foot & Ankle center
23175 Commerce Park Drive. Suite C. Beachwood.Ohio.44122
(*Tel*) 440.588.8197 (*fax*) 440.583.3097

(*Initial*)_____ **Financial Responsibility and Authorization:**

1. I understand that I am ultimately responsible for payment on my account & **PAYMENT IS EXPECTED AT TIME OF SERVICE.**
2. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges that are **NOT covered by my insurance plan,** including refractions, copays, co-insurance and deductibles.
3. EFAC will file claims for companies we are contracted with, including Medicare, Medicaid, and commercial plans. Payments of benefits will be made directly to EFAC.
4. I understand that copays, deposits and deductibles will be taken at the time of service. We accept FSA, HSA, Credit Card (**3% fee will be added**), Check and Cash (**no fees**). There is a **$50** return check fee added to bill if check is returned.
5. Services and any other charges that are not paid by insurance within 30 days are the patients responsibility. I hereby authorize EFAC, to release all information necessary to secure payment of benefits.

(*Initial*)_____ **Fees for Forms, X-Rays copies, paperwork and Cancellation policy:**

1. Disability/Work Related Paperwork **is** $20 **per occurrence. This payment is required in advance. This covers Disability, FMLA or Work-related paperwork. Please Allow 5-7 business days for these to be completed.**
2. **X-Ray Copies:** There will be a $10 Charge for copies of x-rays. Please Allow 5-7 business days for these to be completed.
3. **Copies of medical Records:** Medical records are $50 per chart. This must be paid in advance. This is a non-negotiable fee. Fee Rates can be found at: https://odh.ohio.gov/wps/portal/gov/odh/about-us/offices-bureaus-and-departments/Office-of-General-Counsel/
4. **Cancellation Fee:** We required 24 hours' notice when canceling or rescheduling an appointment. Failure to give notice results in a $50 nonrefundable fee.
5. **No Shows: Two no shows infraction, will result in not being able to schedule again in the future.**

*(Initial)*_____ **I Do Consent**

1. **Treatment of a minor: I the Parent/Legal guardian give permission for treatment of patient under 18. (*Initial)*_____**
2. **I consent having voluntarily presented myself (or my dependent) to EFAC I acknowledge the fact that the evaluation and treatment received was advised or deemed necessary to the judgement of the Physician.**
3. **That by sign the above financial policies that I am the Guarantor. (*Initial)*_____**
4. **That if I present for WORKERS COMPENSATION. That I will have all pertinent information such as but not limited to (insurance information, letter from worker compensation management**

Turn over---→

company. This letter should include the following information (claim number, address, Adjuster's name & phone number. (Your Human resources office will have this information, if payment is not received in 90 days **this bill will be released to you.**

*(Initial)*_____**Retail Products**

In accordance with providing the best possible treatment, some products that the Physician prescribes may not be covered by your insurance and are deemed over-the -counter. Over-the -counter are subject to state taxes and we will provide you with a detailed receipt.

***(Initial)*_____ EFAC's HIPAA Policy**

I acknowledge that I have received or have access to a copy of EFAC's Notice of Privacy Practices. (Via website)

***(Initial)*_____ EFAC's Media Policy**

I **acknowledge that I have received or have access to a copy of EFAC's Media Image and consent form (via website)**

I will participate *(Initial)*_____ Decline/Medical care only *(Initial)*_____

I agree to adhere to the above financial policies and terms. By signing below, I accept the terms & conditions of these policies.

Signature: _____ Date:_____