AZ Podiatry & Foot Surgery

Office of Todd Lamster, DPM
Diplomate, American Board of Foot & Ankle Surgery
Diplomate, American Board of Podiatric Medicine

PATIENT INSURANCE & FINANCIAL AGREEMENT

I hereby authorize the processing of my Medical Insurance either by electronic or manual method by AZ Podiatry and Foot Surgery. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer or insurers I have provided. I further authorize AZ Podiatry and Foot Surgery to release all medical and/or insurance claim information necessary to secure such payment(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits, either to myself or the party who accepts the assignment. Regulations pertaining to Medicare assignment of benefits also apply.

- I understand that I am responsible for any co-payments, co-insurance, deductibles, out-of-network costs, and/or all non-covered services. I also understand that all co-payments are due at the time services are rendered.

I understand that I am ultimately responsible to check on my insurance coverage as well as the eligibility of services related to my foot and ankle care. I understand that it is my responsibility to notify this office at the time of my visit if a referral or pre-authorization is needed for consultation or for any procedures. Furthermore, I understand that if the office has not been advised in advance of my insurance's requirements, and I receive a service that is outside my network or benefits program, I will be responsible for payment.

- ROUTINE FOOT CARE MAY NOT BE A COVERED BENEFIT: This includes the Cutting or Removal of Corns and Callouses. The Cutting or Trimming of Toenails. I am so advised that the cost of these services will be my sole responsibility if they are not a covered benefit under my insurance plan.

- DURABLE MEDICAL EQUIPMENT (Braces, Boots, Shoes, Orthotics, Inserts) MAY NOT BE A COVERED BENEFIT: I understand that some devices dispensed to me during my visit may not be covered according to the benefits of my insurance plan. If so, then I understand that I will be made aware of the cost and can choose to accept it or decline it, and discuss alternatives. If I accept, then I will be financially responsible for the cost of device(s) dispensed.

By signing below, I acknowledge that I have read and understand the above information and agree to all the terms listed above. This agreement will remain in effect until revoked by me in writing. A copy of this document will be considered valid as an original.

Patient Name _____

Signature _____

Date _____

10200 N 92nd Street, Suite 215, Scottsdale, AZ 85258
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