5625 Eiger Road, Suite 110
Austin, TX 78735
(512) 447-4122 (p)
(512) 614-4139 (f)
www.southwestaustinfoot.com

SOUTHWEST AUSTIN
FOOT AND ANKLE CLINIC

170 Benney Lane, Suite 100
Dripping Springs, TX 78620
(512) 894-5100 (p)
(512) 614-4139 (f)
@swaustinfoot

Statement of Financial Responsibility

Fees for Service

At the time of service, the patient is responsible for payment of any applicable co-pay, co-insurance or deductible. Southwest Austin Foot & Ankle Clinic accepts American Express, Visa, Master Card, Discover, and cash or check (with valid Texas Driver's License).

Insurance

An insurance policy is a contract between the patient and the insurance company. It is the patient's responsibility to inform the office of any changes in insurance, contact information, authorization or referral requirements.

The physicians at Southwest Austin Foot & Ankle Clinic perform many procedures that are coded as "surgical" by insurance companies in office, surgical center, and hospital settings. Fees for these services are typically subject to a different deductible than office visits.

We will make every effort to verify benefits with your insurance carrier prior to performing services. However, this is not a guarantee that all services provided will be covered. The patient is financially responsible for all charges.

Forms Policy

Our office is happy to assist with the completion of administrative forms, including temporary disability forms, FMLA forms and work release forms. There is a $10 per page fee for this service.

Missed Appointments

Missed appointments prevent other patients from receiving care in a timely manner. ***We require that patients provide at least 24 hours notice if they have to reschedule or cancel an appointment.*** Please refer to the Cancellation and No-Show Policy for specifics.

Past Due Accounts

Patient accounts must be current in order to be seen by the physician. Past due accounts are subject to collection proceedings.

Returned Check Policy

There is a service fee of $75.00 for all returned checks. This fee must be paid prior to subsequent visits and is not billable to your insurance company.

Agreement to Financial Responsibility Policies and Notice of Privacy Practices

- *Please sign below to indicate that you have read and agree to the Financial Responsibility Policy.*
- *Additionally, by signing below, you acknowledge that you have been provided the opportunity to read and understand the Notice of Privacy Practices.*

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Printed Name of Patient Date of Birth