Bay State Foot & Ankle Specialists, LLC
380 Lowell Street, Suite 102 Wakefield, MA 01880

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service. This includes in office examinations, procedures, dispensing of durable medical equipment, and Hospital based tests and surgical procedures.

I am responsible for understanding the in-network and out-of-network requirements/limitations of my insurance coverage.

Co-payments are due at time of service.

If my plan requires a referral, I must obtain it prior to my visit. If it is not available at the time of the visit, I may be asked to pay for my visit and will be reimbursed if the referral is received within 48 hours of the visit. I can also choose to reschedule my visit until the referral has been received. I understand the office will make every effort to assist in obtaining the referral, but ultimately, it is my responsibility to ensure it has been received.

In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

If I am uninsured, or my health plan is not accepted at this office, I agree to pay for the medical services rendered to me, in full, at the time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Bay State Foot & Ankle Specialists, LLC on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Bay State Foot & Ankle Specialists, LLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnoses and the records of any treatment or examination rendered to me which may be needed to substantiate payment for such medical services, as well as information required for precertification, authorization or referral to other medical providers.

4. **MEDICARE REQUEST FOR PAYMENT (IF APPLICABLE)**

I request payment of authorized Medicare benefits on my behalf for any services furnished me by Bay State Foot & Ankle Specialists, LLC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

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Signature of Patient or Authorized Representative Date

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Print Name of Patient or Authorized Representative

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Relationship to Patient (if applicable)