

**Foot & Ankle Clinic of Spokane, Inc.**  
**Surgery Center of Spokane**  
**Patient Information / Financial Responsibility Form**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone (509)/(208) \_\_\_\_\_ Cell \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name of Primary Doctor \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
Relationship \_\_\_\_\_ Address \_\_\_\_\_ Tel \_\_\_\_\_  
 Married  Single  Other      Employed?  Yes Employer Name \_\_\_\_\_  No  
How did you hear about us? \_\_\_\_\_  
Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
If the Policy Holder is different from the Patient, indicate name of Policy holder here \_\_\_\_\_  
SSN of Policy Holder \_\_\_\_\_ Date of Birth of Policy Holder \_\_\_\_\_

**PERMISSION TO TREAT** – I hereby authorize and request Dr. Jacqueline M. Babol to administer treatment and perform such general procedures as she may deem necessary in the diagnosis and/or treatment of my foot and ankle condition.

**SIGNATURE ON FILE** – I authorize use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.

**HIPAA NOTICE GIVEN**- I have been given a copy of the Privacy Policies of this facility.

**OFFICE FINANCIAL POLICY** – All payments are due at the time of service. I am aware of my responsibility for payment in full regardless of my insurance company's arbitrary determination of usual and customary. If my insurance does not pay for certain procedures, I am responsible. I agree to pay ALL reasonable attorney fees and collection costs in the event of default of payment of my charges. Charges are due within 30 days following date of care. I accept responsibility for payment of the account regardless of insurance coverage or litigation and will continue to receive monthly statements although I may have an insurance claim or legal suit pending. All accounts over 60 days old or over may be sent to a collection agency, the entire account balance will be subject to a 6% monthly finance charge. All payment plans will be charged 19% APR. A maintenance charge of \$6.00 monthly rebilling fee may apply to accounts with open balances. Payments will not be delayed or withheld because of any lawsuit, liens, or insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable. Requests for non customary assistance such as special billing, rebilling, completion of forms, copy of medical records and other information requests are not included in our fees and will be billed separately. X rays may be borrowed but must be returned in 2 weeks. If unable to do so, we have to send them to the hospital to have them copied and the patient is responsible for this charge. Bounced checks will be charged \$28.00 plus balance owing.

I UNDERSTAND THAT I HAVE TO PAY MY UNMET DEDUCTIBLE AND/OR COPAYMENT TODAY.  
How do you wish to pay today?  CASH       CHECK       CREDIT CARD

I hereby authorize charging my credit card for:  All of today's charges including Deductible/ Copay/ Other Charges  
 All future visits' coinsurance.  
 Visa  Mastercard  Discover Card Number \_\_\_\_\_  
Expiration Date \_\_\_\_\_ Signature \_\_\_\_\_

I HAVE READ, COMPLETED, UNDERSTAND AND AGREE TO THE INFORMATION AND TERMS ABOVE.

Signature \_\_\_\_\_ Date \_\_\_\_\_