(INSERT) Office address including and provider name and phone number

Podiatric Treatment Plan

Patient Name:|
D.O.B.:

This treatment plan is only an estimate. Please understand this treatment plan may change at any time during care to be provided. The service(s) and fee(s) listed below may be offered in the provider's office and/or hospital/surgery center. The fee(s) are only the provider's and does not include any of the facility fee(s). Each service that may be provided either on a particular date of service whether it is included in the initial or as a follow-up will have a fee associated with it. This cost estimate will be closely based on the patient/guarantor insurance fee schedule either assigned or contracted. A separate treatment plan will be provided for every visit until the patient and or guarantor's deductible has been met (insurance benefits will be checked before every visit).

FEE(S) FOR SERVICES TO BE PROVIDED:

OFFICE VISIT (NEW OR ESTABLISHED) $_________
XRAY FOOT (BASED ON VIEWS) $_________
XRAY ANKLE (BASE ON VIEWS) $_________
CORTISONE INJECTION (INCLUDING MEDICINE) $_________
WART REMOVAL OR VIA SAL-ACID TREATMENT $_________
INGROWN NAIL CORRECTION(S) PERMANENT OR AVULSION ONLY $_________
PHYSICAL THERAPY MODALITY (DESCRIPTION) $_________
FOOT STRAPPING $_________
ORTHOTIC/AFO OTC OR OTHER DME PRODUCT (DESCRIPTION) $_________
RX ORTHOTIC/AFO CUSTOM MOLDED $_________
FOOT AND/OR /ANKLE SURGERY (SURGEON'S FEE ONLY) $_________
OTHER OR MISCELLANEOUS VISITS, PROCEDURES, MEDICINES AND/OR PRODUCTS $_________

$_______annual (year) health insurance deductible has not met based on the most current benefit information provided by insurance company, therefore the patient/guarantor responsibility on the date these services are provided and any other service thereafter until the $_____deductible is met will be the responsibility of the undersigned. Refunds will be provided when (and if) overpayment occurs (based on payment provided through insurance company on file). Insurance benefits of certain insurance companies may be longer than expected based on financial situation of carrier's underwriter (State of Illinois Plans) and hence a good faith deposit may be required by the patient/guarantor (if so desired).

Lack of compliance on the patient/guarantor's part to make payment for required services may result in longer than estimated length of treatment and additional fees beyond the fees set in this treatment plan. Additional charges may occur based on unforeseen complications with treatment. Good faith pre-determined deposits can be made based on estimate provided. Credit card information will not be kept on file, hence a new form of payment must be provided when services rendered. Certain legal restrictions may apply to this agreement based on provider contract inforce with insurance carrier. Treatment restrictions may also be based on provider clinical judgement and/or patient financial obligation limitation established through this treatment plan.

The undersigned understands that insurance coverage is only an estimate. Patient/guarantor is responsible for all fees not covered by insurance.

Patient/Guarantor Signature _______________________________ Date _________

Doctor Signature ____ Date_________

Witness Signature ____Date _________