William F. Buffone, DPM
Cayuga Foot Care
Eligibility Guarantee Form

I, _________________________ hereby certify that I am covered by my insurance plan and have verified the fact that Cayuga Foot Care is a participating provider on my plan.

I understand that if the above is not true or if I am not eligible under the terms of my Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for the services within 30 days of receiving a bill from the above noted Medical Group or Physician.

I understand that if Workers' Compensation, Medicaid, No Fault, Private Insurance, etc. cover my care and treatment, I have 30 days from the date of my initial visit to provide all necessary insurance information, policy number, etc. In the event that I do not provide the necessary information within that time frame, all charges will be billed at commercial rates and I will be responsible. I agree to pay for all collection agency fees if my account is referred to a collection agency. All co-pays and payment for services not covered by my insurance are due at the time of service. There will be a service charge of five (5) dollars to cover the cost of billing the co-pay.

I understand that I am responsible for having an active referral for each date of service if Health Now, Chickering Student Health, HMO Blue, Child Health Plus, or Total Care insures me. I am responsible for payment for the services if a referral is not on file with my insurance plan.

ASSIGNMENT OF BENEFITS:
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, and other government-sponsored program, private insurance and any other plan to: Cayuga foot Care. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I am aware that all X-Rays taken by Dr. Buffone are the property of Cayuga Foot Care, and that if I need copies of said X-Rays I will give AT LEAST 48 hours notice so that copies may be made. I am aware that there may be a charge of four (4) dollars per X-Ray to cover the cost of processing.

Patient Signature: ____ Date: ____________

Legal Guardian Signature (if minor): ____