

**RUTH ANN COOPER, DPM
4415B AICHOLTZ RD #200
CINCINNATI, OH 45245**

PAYMENT AGREEMENT

Regardless of insurance benefits, or the designation of some other responsible party, I understand that I am financially responsible for the fees. If I am covered by Medicare, I understand that if I am provided specific written notice, in advance, that Medicare is not likely to cover a particular visit or procedure, I will be responsible to pay for that procedure or visit if I agree to proceed with that procedure or visit. Although the Practice will take reasonable steps to obtain reimbursement from the insurance company or the persons listed as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financially responsible party. Further, in the event of payment default, I agree to pay all collection costs in excess of the initial fee (including any legal expenses) and, at the option of the Practice, a reasonable charge for late payments.

All patients are responsible for having full knowledge of their health insurance requirements and restrictions. This includes gaining prior approval or referrals for office visits, procedures, surgery, etc. and communicating to our practice any hospital and/or lab restrictions. All patients must complete our patient information form and provide us with a current valid health insurance card along with a drivers license or photo identification that we may copy and keep in our files.

At the time of the visit, I understand it is my responsibility to obtain a current referral (if required) and pay any deductibles, co-payments, and/or coinsurance not covered by the insurance plan or a government program. Further, I authorize the Practice to file claims on my behalf for covered services and assign all insurance or other payor benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original.

Ruth Ann Cooper, DPM does not treat Workers Compensation injuries nor do we file claims to workers compensation. By consenting to treatment in this office, you hereby declare that your condition is in no way related to a work injury. If after being treated by Dr Cooper, you reveal to us or your health insurance carrier that your treatment by Dr Cooper was for a work related injury, you will be personally responsible for full payment of all services provided to you by Dr Cooper regardless of insurance coverage.

I have read and understand this document and agree to its terms and conditions.

Patient/Parent/Guardian Signature: _____ Date: _____