JOSEPH M. QUEZADA, D.P.M.
Medicine & Surgery of the Foot
Fellow, Academy of Ambulatory
Foot & Ankle Surgery

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Insurance Eligibility Contract

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 insurance plan.

I understand that if the above is not true, or if I am not eligible under the terms of plan, I am liable for all charges for services rendered. I also understand that if the above is true I will pay for all charges and services in a timely manner. If I do not pay in a reasonable and timely manner I will be sent to collections, which will impact my credit score.

I understand that if my insurance (Workman's Comp, Medicaid, No Fault etc.) covers my care and treatment, I have 30 days from the date of my initial visit to provide all necessary information (policy number, comp case number, id number etc.) If I did not do so originally. In the event that I do not provide all of the necessary information, I will be billed the cash price for my treatment, and I will be responsible for paying them to Cayuga Foot Care. I agree to pay for any and all collection agency fees if I do not pay my bill in a timely manner.

I understand that I am responsible for having an *active* referral through my primary care physician for each date of service, depending on whether or not my insurance deems it necessary. I understand that I am responsible for paying the fees for the visit if I do not have an active referral.

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 subsidized 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 the original. I understand I am financially responsible for all charges whether or not they are paid for 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. Joseph M. Quezada DPM are the property of Cayuga Foot Care and that if I need copies made I will give at least 48 hours notice so that those copies can be made. I am aware that there may be a fee of $10.00 per X-Ray sheet, to cover the cost of processing.

Patient Signature: _____ ***Date:*** _____

Legal Guardian Signature (if patient is a minor): _____