Chattanooga Foot Specialists

2707 Citico Ave, Chattanooga, TN 37406

Financial Agreement

- Patient Name_____
- Date of Birth_____
- Responsible Party (If different)_____
- Phone _____

Insurance Information

- Insurance provider_____
- Policy ID/Group # _____

Financial Policy

1. **Financial Responsibility:** I understand I am financially responsible for all services provided, regardless of insurance coverage.

2. **Insurance:** I authorize release of information and assignment of benefits to Chattanooga Foot Specialists.

3. **Deductibles/Copays:** I agree to pay my deductible, copay, or coinsurance at the time of service.

24-Hour No-Show Policy:

- **We require 24 hours' notice to cancel or reschedule an appointment.**
- **Failing to provide 24 hours' notice OR missing an appointment (a "No-Show") will result in a $50 fee billed directly to the patient.**
- **Repeated no-shows may lead to dismissal from the practice.**

Patient Consent

I have read, understand, and agree to the terms above.

- Patient/Representative Signature_____
- Date _____