Claydon Imaging

Dr. Marc Claydon
148 Catherine Lane, Suite B
Grass Valley, CA 95945
(530) 278-6617
FAX (530) 505-2464

Patient Information

Patient Name_____DOB _____

Gender_____

Phone # _____Email_____

Mailing address_____City_____ ZIP_____

- ☐ Insurance Primary_____
- ☐ Secondary Insurance_____
- ☐ Self Pay

Send report/copies to _____

Exam requested_____

Referring Provider_____

Primary Care Physician_____

HIPPA: Foot and Ankle Surgeons of Northern California has my permission to discuss my medical condition and financial information with the following person(s):

_____
_

Phone number Name Relationship to You

I understand that Foot and Ankle Surgeons of Northern California clinic follows the **health Insurance Portability and Accountability act (HIPAA)** of 1996. This is to keep my protected health information (PHI) private.My signature below authorizes the release of any medical information necessary to process claims and request that payment of all assigned benefits be made to the provider of services. I give permission to receive treatment for myself, my minor child, or a patient for whom I have Power of Attorney I have received and read the information and privacy Practices notice.

Emergency/alternate contact: Same as HIPPA? Yes / No

Name_____

Phone ( )_____Relation_____

Signature:_____ Date:_____

Claydon Imaging

Thank you for choosing Claydon Imaging. We are committed to providing you with the best care. To ensure smooth billing and payment, please review our Policy carefully. If you have any questions, feel free to speak with our staff.

Payment Policies

Co-pays and Deductibles

We cannot waive co-pays, deductibles, or coinsurance amounts required by your insurance, as this violates insurance regulations. All co-pays, deductibles, and patient responsibility balances are due at the time of your appointment, unless prior arrangements have been made with our billing coordinator.

Accepted Payment Methods

We accept cash, check, debit card, VISA, MasterCard, Discover, and Apple Pay. For uninsured patients, we offer a discount for payments made in cash at the time of service.

Returned Payments

Returned checks, chargebacks, or returned payments will incur a minimum $35 penalty, in addition to the outstanding balance. After a returned payment, future payments must be made via cash, money order, or cashier's check.

Insurance and Billing

Insurance Billing

While insurance is a contract between you and your insurer, we will file claims on your behalf as a courtesy. It is your responsibility to ensure that we have complete and accurate insurance information & your responsibility to make sure we are in network with your insurance before your arrival. Failure to provide correct information may result in you being billed directly for any unpaid balances.If your insurance pays you directly, you must forward that payment to us immediately.Please be aware that any services not covered by your insurance are your responsibility.

Referral and Pre-Authorization

If your insurance requires a referral or pre-authorization, you are responsible for obtaining it. If we do not receive the required authorization before your appointment, we may need to reschedule. Failure to obtain the necessary approval could result in reduced payment from your insurance, leaving you responsible for the balance.

Out-of-Network Insurance

If we are not an in-network provider for your insurance, you will be responsible for payment in full at the time of service. We will submit the initial claim to your insurance, but if the claim is not paid within 60 days, you will be responsible for the full amount.

Workers' Compensation

If your visit is related to a workers' compensation claim, you must provide authorization and claim details from your employer. If the claim is denied, you will be responsible for

payment.

Self-Pay and Uninsured Patients

Self-Pay Patients

For uninsured patients or those with insurance we do not accept, payment in full is required at the time of service. Extended payment plans may be available on a case-by-case basis. Please speak with our practice manager for assistance.

Other

I, as the patient or the parent/legal guardian, consent to the use of ambient listening technology and third-party audio recording during clinical encounters.

Acknowledgment

By signing below, you acknowledge that you have read and understood the Policy. You agree to assume responsibility for payment of services rendered, including any amounts not covered by your insurance. You authorize the release of medical information necessary to determine insurance benefits and agree to cooperate with any credit investigation if necessary.

Patient/Responsible Signature: _____**Date:** _____

Relationship to Patient (if applicable): _____