Foot and Ankle Institute

Name:_____

Chart#_____

Out of Network Notification
Medicaid Insurance

Foot and Ankle Institute is not a provider for Medicaid Insurance. Our office and providers are Out of Network for this insurance. Therefore, as a patient you will be responsible for any co-insurance, deductible, or other balance(s) that may be left from the primary insurance. As an Out of Network Provider we can not bill Medicaid.

By signing this form you acknowledge that you have been notified that the provider is Out of Network and you wish to see the provider at your own cost.

Patient Information

Name:_____ DOB:_____

Address:_____

_____

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Primary Insurance Coverage:

Carrier:_____ ID Number:_____

Patient/Guardian Signature:_____ Date:_____

Guardian Name Printed:_____ Relationship:_____

Witness Signature:_____ Date:_____