Family Footcare

421 West Stone Drive
Kingsport, Tennessee 37660
(423) 245-4100 Fax (423) 245-0463
Mark C. Baxter, D.P.M.

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependant to be made directly to Mark C. Baxter, DPM. This authorization is valid until I notify Mark C. Baxter, DPM in writing that it's been revoked.

I understand that I am responsible for giving Mark C. Baxter, DPM the correct insurance information at the time services are rendered. Mark C. Baxter, DPM agrees to bill your primary insurance carrier. If you have more than one insurance we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days the balance becomes your responsibility. All insurance information must be provided to our office, at the time of service.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.

I agree to pay for non-covered services under my insurance plan (services for which I have policy exclusion).

I understand that Mark C. Baxter, DPM is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Mark C. Baxter, DPM office expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a $10 re-billing fee, for each statement that we mail. If you have made arrangements with our office we will not charge the re-billing fee for statements sent. Your account will be turned over to collections if you do not fulfill the terms of your financial arrangements.

I understand that there is a $25 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a $25 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductible, co-pays, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and any attorney fees and or court costs incurred by this office and will no longer be considered an acceptable patient.

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Patient or Patient's Guardian or Legal Representative's Signature Date