

Cupertino Podiatry, Inc.

Adult & Children's Lower Extremity Biomechanics
Reconstructive Foot & Ankle Surgery
Sports Medicine

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Diplomate, American Board of Podiatric Surgery

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Contract of Fiscal Responsibility

I, _____ hereby assign all medical and surgical benefits to Cupertino Podiatry, Inc. to which I am entitled arising from any foot or ankle treatment received. I authorize this office to release any and all information, as needed, to secure payment on my behalf.

I understand that failure to cancel my appointments without 24 hour notice will result in a missed appointment fee in which I will be financially responsible.

I understand that I am financially responsible for all services and supplies rendered to me or my dependents. As a courtesy, Cupertino Podiatry, Inc. will bill my insurance carrier for all services rendered or supplies received.

Cupertino Podiatry, Inc. will make three attempts to collect from my insurance carrier within a sixty day (60) period. If payment has not been secured within sixty days from the date of my appointment, the balance, will become my financial responsibility.

I understand that any payments made by insurance carrier directly to Cupertino Podiatry, Inc. for services in which I have already paid for will result in a refund issued to me. Please note that refunds are issued at the beginning of each month.

PATIENT SIGNATURE: _____

DATE: _____