Custom Orthotics Fitting Financial Agreement

Patient Name: _____ **Date of Birth:** _____

Date of Orthotics Fitting: _____ **Orthotics Description:** _____

This agreement ("Agreement") is made between the undersigned patient ("Patient") and HMI Foot and Ankle Group, SC. (“Office"), located at 19255 Everett Lane, Suite B, Mokena, IL 60448.

1. Purpose of Agreement
The Patient acknowledges that they are receiving a fitting for custom orthotics, which may involve casting for each foot to ensure an accurate mold for the custom device.

2. Deposit Requirement
A deposit of **$100** is due on the date of service for the fitting to cover the Office's expense in creating the casting for each foot. This deposit is required at the time of the fitting and will be applied toward the Patient’s final balance once all insurance payments have been processed.

3. Insurance Billing
The cost of the custom orthotics will be submitted to the Patient’s insurance provider for reimbursement. The Patient agrees to allow the Office to submit the orthotics claim on their behalf. The insurance company will be responsible for paying a portion of the cost, if applicable.

4. Deposit Application
The $100 deposit collected today will be applied toward the Patient's balance after all insurance payments have been processed and posted to the Patient’s account. Any remaining balance owed, after insurance reimbursement, is the responsibility of the Patient or Guardian.

5. Outstanding Balance
If there is any remaining balance after insurance payments have been posted, the Patient agrees to pay the outstanding balance in full within 60 days of notification from the Office.

6. Refund of Credits
If any credits are due to the Patient following insurance processing and payment, the Office will refund the credit to the Patient in a timely manner.

7. Acknowledgment and Agreement
By signing below, the Patient (or legal guardian) acknowledges that they have read, understood, and agreed to the terms and conditions outlined in this Agreement. The Patient agrees to comply with the terms of this Agreement, including the payment of any outstanding balance.

Patient or Legal Guardian Signature: _____

Printed Name: _____ **Date:** _____

Office Representative Signature: _____ **Date:** _____

Dr Haytham Mansour, DPM, PhD
19255 Everett Lane, Suite B, Mokena, IL 60448 3231 Euclid Ave, Suite 400, Berwyn, IL 60402
Office: 630.656.3171 Fax: 630.657.0131 Email: staff@hmifootandankle.com www.hmifootandankle.com