

IMPORTANT

Please read carefully and sign where indicated

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I assign all insurance benefits to Foot & Ankle Physicians, P.A. for services rendered. I authorize Foot & Ankle Physicians, P.A. to release all information necessary to secure payment of benefits. I authorize use of this signature on all insurance submissions.

Patient or Guardian Signature

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Foot & Ankle Physicians, P.A. for any service furnished to me by their doctors. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine what benefits are payable. In Medicare assigned cases, the physician or supplier agrees to accept the dollar amount Medicare approves as the full charge and the patient is only responsible for the deductible, co-insurance and non-covered services.

Medicare Patient or Guardian Signature

Date

REFERRALS & AUTHORIZATIONS

It is the patient's responsibility to obtain proper referrals or authorizations that may be required by their insurance company prior to seeing the doctor or full payment will be due from the patient at the time services are rendered.

Patient or Guardian Signature

Date