Authorization to Release Medical Benefits

I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Plaza Foot Care Center.

Please remember that medical insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability of payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment is to be considered as valid as an original.

Date____________________________________

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Signature of responsible party

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the Plaza Foot Care Center, PC for any services furnished me by its physician(s). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date___________________________________

____
Signature of Beneficiary

Lifetime Consent

I request that payment of authorized Medigap benefits be made on my behalf to the Plaza Foot Care Center, PC for any services furnished me by its physician(s). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date____________________________________

____
Signature of Beneficiary

Medigap Insurer ____
Patient's Medigap # ____