Release of Billing Information

_____(initial)I hereby authorize PA foot & Ankle Associates to; (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from PA Foot & Ankle Associates on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

Assignment of Benefits

_____(initial)I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), include Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to PA Foot & Ankle associates for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Acknowledgement of Receipt of Notice of Privacy Practices

_____(initial)I acknowledge that I have received a copy of PA Foot & Ankle Associates Notice of Privacy Practices. This notice describes how PA Foot & Ankle Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and the rights I may have regarding my protected health information.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient