

FOOT & ANKLE SURGICAL ASSOCIATES

CONSENT TO TREATMENT AND INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize, medical care for _____. I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for payment for all services according to Foot & Ankle Surgical Associates policy, regardless of any pending insurance claims. I authorize the physician to release my information to the mentioned insurance compan(ies) for the processing of claims.

I understand that my express consent is required for the medical provider to release any information in relation to the diagnosis and/or treatment of HIV (AIDS virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness. If I have been treated or diagnosed in connection with HIV (AIDS virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness, you are specifically authorized to release to the insurance company listed on the other side of the form or entity all information or medical records relating to the diagnosis, testing or treatment*.

Patient Signature _____ Date _____

If a minor, by parent or legal guardian _____ Date _____

*If the patient has reached his-her 14th birthday, ONLY the patient may authorize disclosure relating sexually transmitted disease.

MEDICARE AUTHORIZATION AND ASSIGNMENT

I authorized any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information necessary for this or a related Medicare claim/other insurance claim. I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts the assignment. Regulation pertaining to Medicare assignment of benefits applies. I understand it is mandatory to notify the health care provider of any party who may be responsible for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Patient Signature _____ Date _____