SIGNATURES

Acct # ________________ Date of Birth: ___________________

TREATMENT AUTHORIZATION & CONSENT TO RELEASE PRIVATE HEALTH INFORMATION:

I hereby authorize treatment by Prestige Podiatry. I understand that my healthcare information is private and that my insurance carrier will require this information in order to process claims for payment of services rendered by this medical provider. I authorize the release of pertinent medical information to my insurance carrier(s). I also authorize payments to be made directly to this medical provider by my insurance carrier(s).

Signature of Responsible Party_________________________________Date______________

Financial Agreement:

I agree that I am responsible to pay co-pay amounts, deductibles and services not covered by my insurance company. I also understand that I will be responsible for any expense associated with the collection of a debt owed to the provider by me (i.e. Attorney fee, court cost or collection agency fee).

Signature of Responsible Party _______________________________________ Date_______

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Prestige Podiatry for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Responsible Party_________________________________ Date_____________