

**SIGNATURES**

**Acct #** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**TREATMENT AUTHORIZATION & CONSENT TO RELEASE PRIVATE HEALTH INFORMATION:**

I hereby authorize treatment by Achilles Podiatry Group. 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).

I understand verification of my insurance benefits **does not** guarantee payment and that I will be responsible for any charges not covered under my plan.

**I understand it is my responsibility to know my insurance plan coverage and benefits. (Insurance Co-Pay is due at time of service)**

**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 Achilles Podiatry Group 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** \_\_\_\_\_