

FOOT AND ANKLE PHYSICIANS, P.A.

SIGNATURE ON FILE

- I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
- I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
- I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY.
- I AUTHORIZE DIRECT PAYMENT TO MY DOCTOR.
- I AUTHORIZE MY MEDICAL RECORDS TO BE RELEASED TO MY REFERRING DOCTOR.
- I AUTHORIZE PERMISSION FOR ANY APPEALS DONE ON MY BEHALF TO MY INSURANCE COMPANY.
- I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR MY BILL IF DENIED BY MY INSURANCE COMPANY
- **I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR OBTAINING ANY REFERRALS REQUIRED BY MY INSURANCE COMPANY AND BEING AWARE THAT ALL REFERRALS ARE MADE OUT APPROPRIATELY TO MY DOCTOR.**

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: ____/____/____