

REASON FOR YOUR VISIT: _____

INSURANCE, ASSIGNMENT AND HIPPA AUTHORIZATION

Co-payments are due at the time of service. We will bill all contracted insurance companies, however you are ultimately responsible for all charges whether or not paid by your insurance company. For your convenience we do accept Checks, Cash, Visa or Mastercard.

I hereby authorize Neamand Foot & Ankle Center and/or its staff to disclose my individually identifiable health information to the insurance carrier(s). Neamand Foot & Ankle Center will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process the claims. This includes disclosing your protected health information to other physicians who treat you or to home health agencies that provide care to you. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient, Guardian &/or Insured Signature _____ Date: _____