

# Atlantic Podiatry Associates

**Patient Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

## Assignment and Release

I hereby authorize Atlantic Podiatry Associates to release medical information pertinent to the filing of insurance claims for the patient named above. I authorize my insurance carriers to pay benefits directly to Atlantic Podiatry Associates, on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Atlantic Podiatry Associates, for charges for the above patient regardless of my insurance coverage. I also understand that Atlantic Podiatry Associates is not ultimately responsible for collecting my insurance or negotiating settlements of claims. A copy of this document is considered as valid as an original.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Relationship: \_\_\_\_\_

## Medicare Authorization

I request that payment of authorized benefits be made to Atlantic Podiatry Associates for any services rendered to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurances and deductibles are based upon the charge determination of the Medicare carrier.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_