Medicare Lifetime Signature on File – ***Please sign this section IF YOU HAVE MEDICARE***

I request that payment of authorized insurance benefits be made on my behalf to Ability Foot & Ankle for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. In medical assigned cases, the physician agrees to accept the charge determination of the medical carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. In Medicare non-assigned cases, the patient is responsible for the entire charge.

Patient Signature:_____ Date:_____

Assignment of Benefits

Assignment of Benefits to Physician: I herby assign all medical and/or surgical benefits, to which I am entitled including Medicare, private insurance, and any other health benefit plan to Ability Foot & Ankle. I understand that I am financially **responsible** for the charges not covered by this authorization or insurance. I hereby authorize Ability Foot & Ankle to release any information relative to medical care received by me.

HIPAA Compliance Acknowledgement

Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Office Policies

I understand that my insurance may require a referral to be seen at Ability Foot & Ankle and that it is my responsibility to obtain a referral through my Primary Care Physician. If this referral is not obtained prior to my visit, I WILL BE RESPONSBILE FOR ALL CHARGES INCURRED. I understand it is my responsibility to know if the doctor is (or is not) in my insurance provider network. I understand any broken appointment(s) cancelled less than 24 hours from scheduled office appointment, or appointments where I fail to show without notification may incur a $30.00 no show fee.

Medical Condition Update

I understand that it is my responsibility to provide any updates to the doctor regarding medical conditions, allergies and medications.

I have read and understand the policies above and agree to accept responsibility.

Patient Signature: _____ Date: _____