

Patient Responsibility Agreement

I hereby give permission to Affiliated Podiatrists, P.C. to examine, diagnose, and treat my feet and/or ankles medically, podiatrically and/or surgically. I accept full responsibility for any charges rendered to the above named patient. Payment is due for services when rendered unless other arrangements have been made in advance in writing. I understand that I am responsible for all deductibles, co-payments and non-covered service charges. It is also my responsibility to obtain and monitor my own referrals, as outlined in my individual insurance policies.

I hereby authorize Affiliated Podiatrists to release any information regarding services rendered by them, and allow a photocopy of my signature to be used to file insurance. I authorize payment of medical benefits to Affiliated Podiatrists, P.C. and understand that Affiliated Podiatrists, P.C. may file some types of insurance as a courtesy to me. However, I am responsible for staying in contact with my insurance company to assure that they make payments in a timely manner. In the event that my insurance pays none or only a portion of Affiliated Podiatrists P.C. bill, I will be responsible for the remaining balance.

Signature: _____
(Billable Party)

STATEMENT OF DISCLOSURE

Affiliated Podiatrists, P.C. is allowed to discuss my medical information with: (please list anyone you are comfortable with us sharing your medical history and conditions)

ATTENTION: MEDICARE PATIENTS ONLY
MEDICARE LIFETIME SIGNATURE AGREEMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers, or billing agents of the physician or supplier, any information needed to be used in the place of the original and I request payment under Medicare to be made either to be or to the physician, provider or supplier identified below for services or supplies furnished by that physician, provider, or supplier during my lifetime.

Patient Medicare Beneficiary Lifetime Signature: _____

Health Insurance Number: _____

Date: _____