Insurance

Patient's Name: _____

Who is responsible for this account? _____

Relationship to patient, if not self: _____

Insurance company: _____

Insurance ID #: _____

Group number: _____

Subscribers DOB: _____ SSN#: _____

Is patient covered by additional insurance? ☐Y ☐N If Y, please list: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ _____(insurance company) and assign directly to Nova Family Podiatry all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship to patient Date

I request that payment of authorized Medicare benefits be made either to me or my behalf to Nova Family Podiatry, for any service furnished by that practice. 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 that my signature requests that payment be made and authorized 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 is releasing of the information to the insurance agency shown. In Medicare signed cases, the physician or supplier agrees to accept the charge deductible, coinsurance, and non-covered services. Coinsurance and the deductible is based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date