Alm Foot Care

MEDICAL & SURGICAL TREATMENT OF FOOT DISORDERS

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.
I authorize release of pertinent information to all my insurance companies.
I understand that I am ultimately responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment direct to my doctor.
I permit a copy of this authorization to be used in place of the original.

_____

Patient Name (please print)

_____ _____

Signature (patient, parent or authorized representative) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____

Patient Name (please print)

_____ _____

Signature (patient, parent or authorized representative) Date

PERMISSION TO PROVIDE EXAMINATION & TREATMENT

I hereby give permission to the doctor to administer examination and to perform treatment procedures as may be deemed necessary in the diagnosis and treatment of my foot conditions. I hereby certify that the information I have provided is true and correct to the best of my knowledge.

_____

Patient Name (please print)

_____ _____

Signature (patient, parent or authorized representative) Date