



Patient Name: _____

D.O.B: _____

Patient Release Form

Medicare Benefits to Provider. Physicians and Patient:

I certify that the information given by me in applying for payment under File XVII of the Social Security Act is correct. I authorize any holder of medical information or other information about me to release the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services and authorize such physicians of organization to submit a claim to Medicare for payment.

Authorization for Medical and Diagnostic Treatment

I, the undersigned as a patient or his/her authorized representative, hereby authorized Family Podiatry of Central Florida and/or its representative(s), to treat the condition(s) which appear indicated by the admission complaints and findings. I will be informed of the modes of treatment, risks involved, and the nature of the procedure(s) to be done. No guarantee has been made that my present condition will be cured.

Release of Medical Records

Release of medical records and medical information; I, the undersigned, as the patient or his/her authorized representative, hereby authorize Family Podiatry and/or its representative(s) to release to my insurance company(s) or other appropriate agency(s) that information which is necessary to validate this claim.

Assignment of Insurance and Financial Responsibility

Assignment of insurance and financial responsibility; I hereby authorize payment to Family Podiatry of Central Florida, for benefits otherwise payable by me, including major medical insurance. I understand that I am financially responsible for all charges incurred during this treatment program, whether or not paid by said insurance. It is my responsibility to pay any deductible amount or any other balance not paid by my insurance in 45 days.

The Undersigned

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or his/her authorized representative, to release Family Podiatry of Central Florida or its employees from any liability which may arise from this action, whether or not foreseen at present.

Receipt of Notice of Privacy Practice

I, _____, have received a copy of Family Podiatry of Central Florida notice of privacy policy practices.

I authorize the release of my medical records to the following person(s) named below.

X _____

Signature of Patient or Legal Representative

Date