

**SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT,  
AND TREATMENT CONSENT.**

Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is **NOT** a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance:** I request that payment of authorized benefits be made on my behalf to **The Family Footcare Center** for services furnished to me by **The Family Footcare Center**. 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 release of medical information necessary to pay the claim. **The Family Footcare Center** accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.
2. **Secondary Insurance:** I understand that if other health insurance is indicated my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **The Family Footcare Center** if possible or otherwise to me, at which time I would forward all payments to **The Family Footcare Center**.
3. **Release of Information:** **The Family Footcare Center** may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract with **The Family Footcare Center** for reimbursement for services rendered and (2) any health care provider for continued patient care. **The Family Footcare Center** may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.
4. **Non-Covered Services:** I understand that **The Family Footcare Center** contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services, which are determined by the health care insurance plan as non-covered services.
5. **Financial Agreement:** I agree that in return for the services provided to me by **The Family Footcare Center** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **The Family Footcare Center** for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **The Family Footcare Center**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.
6. **Divorced Parents:** We do **NOT** second party bill. The parent/legal guardian bringing the child to our facility will be responsible for required co-payments, deductibles etc. at the time of service.
7. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of **The Family Footcare Center Notice of Privacy Practices**.
8. **NOTICE: ANYONE UNDER THE AGE OF 18 WILL NOT BE SEEN WITHOUT A PARENT OR GUARDIAN PRESENT UNLESS YOU ARE AN EMANCIPATED MINOR.**
9. **TREATMENT CONSENT: By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

\_\_\_\_\_  
**SIGNATURE of Patient, Guardian or Representative**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**Please PRINT name**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**BIRTH DATE**

**\*\*If an individual's personal representative signs an authorization, the representative's authority is based on: \_\_\_\_\_ (e.g. state law, court order, etc.)**