

FOOT SPECIALIST OF BIRMINGHAM

Agreement to Pay:

I understand that I am financially responsible for any charges deemed non-covered by my insurance company. I agree if my account is turned over for collections to pay all collection fees, attorney fees, and court costs. The maximum allowed by law will be charged on any returned check or item for insufficient funds.

Authorization:

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

It is my responsibility to notify the doctor's office of any change in my insurance. It is my responsibility to notify the doctor's office which insurance is primary, secondary, and tertiary. It is my responsibility to obtain a referral if my insurance requires one.

Signature _____ Date _____