

American Foot Clinic, Inc

1104-8 S. Air Depot Blvd
Midwest City, OK 73110
(405)733-2783

W. Dale Hall, D.P.M.

10710 N. May Ave.
Oklahoma City, OK 73120
(405)749-8636

Dear Patients:

Our goal is to provide you with the best possible care we can give you. This sometimes includes materials or supplies that your insurance company does not cover. This would be considered an out of pocket expense and are due at the time services are rendered.

In the event the insurance company does reimburse us, we will be happy to issue you a refund (what insurance paid).

Some of these items are:

Strapping tape and pads

Pads of any type

Orthotics of any nature

Fungal Soaks

Surgery or Post Op Kits

Casting Materials

Some injections

Any over-the-counter take home items

INSURANCE ASSIGNMENT OF BENEFITS

Assignment & Release: I, the undersigned, certify that I or my dependent have insurance coverage with _____ and assign payment directly to Dr. William Dale Hall, D.P.M. all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

****Patient or Responsible Party** _____ **Date** _____

****Responsible Party** _____

Medicare Authorization: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. William Dale Hall, D.P.M for any services furnished me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests payment be made and authorizes release 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 authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based on the charge determination by the Medicare carrier.

****Patient (Beneficiary) or Responsible Party** _____

****Date** _____

I understand that honest and complete answers to each question stated on the Patient Information form are important to the provision of my medical care and I have answered them to the best of my ability. I understand that if I am uncertain about any question on the form, I should ask the doctor or a member of the office staff for assistance.

Patient or Responsible Party _____

Date _____