

AMERICAN FOOT CLINIC
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INSURANCE AUTHORIZATION FORM

Dear Patients:

It is sometimes necessary to use materials and medications to ensure our patients the best possible care. **Many of these supplies or medications are not covered with your office visit.** These are an out of pocket expense due at the time services are rendered. Many insurance companies do not cover these supplies or take home medications.

In the event your insurance company does pay for any of these items we will refund your money as soon as possible.

An example of some of these items are as follows:

- Strapping Tape and Pads
- Pads of any type
- Orthotics of any nature
- Fungal soaks
- After surgery kits supplied for post operative care
- Casting Materials
- Injections

ASSIGNMENT AND RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by 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.

Responsible Party Signature: _____

Relationship: _____

Date: _____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. 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 benefits payable for related services. I understand my signature request that 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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____

Date: _____

FILL IN ONLY IF YOU DO NOT HAVE YOUR INSURANCE CARD:

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Is patient covered by additional insurance? Yes ___ No ___

Subscriber Name _____

Birthdate _____ SSN _____ - _____ - _____

Relationship to Patient _____

Insurance Co. _____

Group Number _____