Family Foot Health Center, P.C.

Assignment of Benefits, Release Form & Financial Responsibility Policy

Patient Name: _____Date of Birth: _____

Primary Insurance:_____
Policy #:_____Group #: _____
Subscriber Name:_____ Subscriber Birthdate:_____
Subscriber Employer: _____

Secondary Insurance:_____
Policy #:_____Group #: _____
Subscriber Name:_____ Subscriber Birthdate:_____
Subscriber Employer: _____

I hereby instruct and direct the mentioned insurance companies to pay directly to:
Family Foot Health Center, P.C.4527 Rt. 9 N, Howell, NJ 07731

This is a direct assignment of my rights and benefits under this policy

I understand and agree that, regardless of my insurance status, **I am ultimately responsible for the balance of my account** for any professional services rendered. I am responsible for any **co-pays, co-insurances, deductibles, referrals, non-covered services and/or denial of benefits. I am responsible to know my benefits including any podiatric or other limits to my insurance plan.**

Your insurance benefits are a contract between you and your insurance company. I will contact my insurance company immediately to straighten any matters that are hindering payment. I will pay my balance in full within 45 days unless other arrangements have been made with the billing department.
I authorize the release of any information pertinent to my medical treatment to any doctor, insurance company, adjustor or attorney involved. I authorize the use of this signature on all insurance submissions.

Is today's visit related to an auto accident, Worker's Compensation or school incident?
Yes _____ No _____

FINANCIALLY RESPONSIBLE PARTY:

Print Name: _____Signature_____
Date: _____Relationship (if not self:_____