Family Foot Health Center, P.C.

Assignment of Benefits, Release Form & Financial 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 North
Howell, NJ 07731

<u>This is a direct assignment of my rights and benefits under this policy</u>

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, uncovered services and/or denial of benefits. I will contact my insurance company immediately to straighten any matters that are hindering payment.

I also authorize the release of any information pertinent to my medical treatment to any doctor, insurance company, adjustor or attorney involved.

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

Signature ____________________________________ Date: ______________________

Relationship (if not self): ____