AUTHORIZATION FOR INSURANCE PAYMENT

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

THIRD INSURANCE: _____

FOURTH INSURANCE: _____

MEDICARE AND ALL OTHER INSURANCES AUTHORIZATIONS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME RELEASED TO THE SOCIAL SECURITY ADMINSITRATION OR ITS INTERMEDIARIES OR CARRIERS FOR INFORMATION NEEDED FOR THIS OR RELATED MEDICARE CLAIMS. I REQUEST THAT THE PAYMENT OF SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SEVICES OR AUTHORIZE SUCH PHYSICAIN OR ORGANIZATION TO SUBMIT CLAIMS TO MEDICARE FOR ME. I ALSO REQUEST THAT THIS APPLY TO ANY OTHER INSURANCE I MAY HAVE.

I AUTHORIZE DR. COSIMO A RICCIARID, D.P.M.AND OR/ DR THOMAS A FUSCO, D.P.M., TO RELEASE ANY INFORMATION NEEDED FOR THIS OR OTHER RELATED INSURANCE CLAIMS. I REQUEST THAT THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I REQUEST ALL ASSIGNED CLAIMS TO BE MADE PAYABLE TO THE ABOVE SAID DOCTORS.

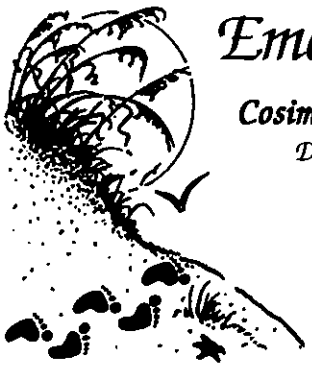
SIGN _____ **DATE** _____

BY _____ **(TITLE OR RELATIONSHIP)**

I UNDERSTAND I MAY BE RESPONSIBLE FOR PAYMENT OF SERVICES AND IN CASE OF DEFUALT, I MAY BE RESPONSIBLE FOR REASONABLE ATTORNEY'S FEES AND COSTS OF COLLECTIONS.

SIGN _____ **DATE** _____

BY _____ **(TITLE OR RELATIONSHIP)**



Emerald Coast Podiatry and Wound Care Center

Cosimo A. Ricciardi, D.P.M., FACFAS
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeons

Robert D. Siwicki, D.P.M., AACFS
Diplomate, American Board of Multiple Specialties in Podiatry (Podiatric Surgery & Medicine)
Fellow of the College Certified Wound Specialists

Thomas A. Fusco, D.P.M., AACFAS
Associate American College of Foot and Ankle Surgeons

PATIENT'S NAME _____

TO AVOID A $25 CANCELLATION FEE, A 24 HOUR NOTICE IS REQUIRED.

I UNDERSTAND THAT THE FEE MUST BE PAID PRIOR TO RESCHEDULING.

THIS FEE IS NOT COVERED BY INSURANCE.

SIGNATURE: _____

DATE: _____

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