Emerald Coast Podiatry and Wound Care Center

AUTHORIZATION FOR INSURANCE PAYMENT

Primary Insurance:
Insurance Name: _____

Policy Number: _____ Group #: _____

Secondary Insurance:
Insurance Name: _____

Policy Number: _____ Group #: _____

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 COSIMO A RICCIARDI, D.P.M./NEIL PATEL, 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 DOCTOR.

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.

_____ _____
Signature **Date**

_____ _____
IF PATIENT IS UNABLE TO SIGN: PARENT, GUARDIAN OR LEGAL REPRESENTAVIE **DATE**

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVARY PRACTICES

I acknowledge that I was provided a copy of the Notice of the Privacy Practices and that I have read them and understand them or declined the opportunity to read the Notice of Privacy Practices.

_____ _____ _____
Name (PLEASE PRINT) **SIGNATURE** **DATE**

_____ _____
IF PATIENT IS UNABLE TO SIGN: PARENT, GUARDIAN, OR LEGAL REPRESENTIVE **DATE**

EMERALD COAST PODIATRY & WOUND CARE CENTER
COSIMO A. RICCIARDI,D.P.M.
NEIL PATEL, D.P.M.

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: _____