ASSUMPTION OF RESPONSIBILITY AGREEMENT

The information supplied on the **Patient Information Forms** is accurate and true to the best of my knowledge. I do understand that all office visits are due and payable at the time of each visit unless other arrangements have been made with the financial office. I understand that I am ultimately responsible to pay for the services rendered, including reasonable attorney's fees and the cost of collection in the event of default. I understand there is a $35.00 fee for returned checks.

I do understand that insurance co-pay amounts and amounts for dispensed supplied must be paid on the day I am treated. If my insurance does pay, I will be reimbursed promptly. I understand that some services or benefits may not be covered by my insurance plan, and I agree to pay for charges that my insurance company determines to be my responsibility.

I hereby assign to Associates in Foot and Ankle Care, Inc. insurance payments, including Medigap, for medical services rendered to myself or my dependents for treatments. I also authorize holders of hospital or medical information to insurance carriers to determine benefits payable for related services.

_____ _____

Signature of Responsible Party Date of Signature

PATIENT'S MEDICARE AUTHORIZATION

I request that payments of authorized Medicare benefits be made on my behalf to Associates in Foot and Ankle Care, Inc. for and services furnished me by the medical group. I authorize any holder of hospital of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services.

I understand that I am responsible for Medicare coinsurance, deductible and any services rendered, but not covered by Medicare for which I have agreed in advance to pay.

I understand that Medicare does not pay for dispensed supplied. These are provided as a convenience to me and I will pay for them on the day I receive them.

I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient or Adult Guardian Date of Signature
