SHEEHY ANKLE FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director

AUTHORIZATION FOR TREATMENT

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this information on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits.

I understand that if I am in default of payment, I will be responsible for any attorney or collection fees.

Signature: _____ **Date:** _____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the PAUL L. SHEEHY, JR., D.P.M., for any services furnished me by the physician. I authorize any holder of medical information about me to release PAUL L. SHEEHY, JR., D.P.M., and its agents any information needed to determine these benefits or benefits payable for related services.

Signature: _____ **Date:** _____

SECONDARY INSURANCE
I understand that my secondary claim is billed as courtesy only and will be submitted to the appropriate party ONE TIME. After that one-time submission if the insurance company does not pay within 60 days or denies the claim, I (the patient) will be financially responsible to pay.

Signature: _____ **Date:** _____

PATIENT AGREEMENT
I understand that payment is due at the time of service, including co pays and/or deductible. I certify that the information provided on this form is correct. I authorize the release of information including medical information to this organization and all insurance organizations involved with my claim. I understand that if I am in default of payment, I will be responsible for any attorney or collection fees. I authorize my physician to prescribe medication and to give me reasonable and proper medical care by today's standards.

Signature: _____ **Date:** _____

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ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the HIPAA Federal Privacy Guidelines and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature