Wolff
PODIATRY

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

Depending on your insurance coverage, some patients will have partial financial responsibility for the services that they receive from Wolff Podiatry.
Signing this form authorizes Wolff Podiatry to disclose information from your medical records as it is deemed reasonably necessary, in a HIPPA Compliant Manor.
If you are a member of a Managed Care Plan, it is **YOUR** responsibility to ensure that you adhere to your plan's requirements listed in your member agreement. It is your responsibility to obtain a valid referral or authorization from your PRIMARY CARE PROVIDER, (PCP) for your appointments with Wolff Podiatry.
If you see a PCP that is not listed as your PCP with your Health Plan, your Health Plan may deny coverage for that visit, and you will be financially responsible. If you do not have active insurance coverage, or you are receiving services that are not covered by your Health Insurance Benefit Plan, you are considered a Self-Pay Patient and will be responsible for any balance related to the services you received.

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGEMENT:

1. I have read and understand the information provided in this form above.
2. I authorize the HIPPA COMPLIANT RELEASE of my medical records, including all HIV/AIDS testing and treatment information, to my health insurer for claim processing and payment purposes.
3. I authorize that my insurance benefits are to be paid directly to Wolff Podiatry.

I acknowledge that I am responsible for all balances that are deemed by my health insurance plan to be my responsibility including deductibles, co-insurance, copayments, and other services not covered by my plan.

PARENT/GUARANTOR SIGNATURE_____

PRINT NAME _____

DATE_____