



**ASSIGNMENT OF RELEASE OF INSURANCE**

I authorize and assign directly to HMI Foot and Ankle Group, S.C. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the HMI Foot and Ankle Group, S.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

**MEDICARE AUTHORIZATION ONLY**

We will bill Medicare only those services that are defined as medically necessary. When services are requested that are not medically necessary the payment will be solely the patient's responsibility.

I authorize any holder of medical or other information about me to release to the Social Security Administration and HealthCare Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claims. I permit a copy of this authorization to be used in place of the original. And request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I request that payment of authorized Medicare benefits be made either to me or on my behalf to HMI Foot and Ankle Group, S.C., for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I agree that I am responsible for any balance on my account whether paid in full, in part, or no part by my insurance carrier. I agree that I have read all the policies above and give consent for treatment.

**CONSENT FOR TREATMENT**

I certify that the above information is true and correct to the best of my knowledge. I give permission to the Doctors of HMI Foot and Ankle Group, S.C. to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankle(s).

**Minor Patient Policy**

Minors (under the age of 18 years) must be accompanied by a parent/guardian that can sign for their care on each appointment.

**FINANCIAL POLICY**

I agree that I am responsible for any balance on my account whether paid in full, in part, or no part by my insurance carrier. I agree that I have read all the policies above and give consent for treatment.

Co-payments are DUE on day of service

HMO/PPO members that require referral forms MUST present them prior to seeing the doctor

**Agreement to Pay Percentage collection fee.**

Consumer agrees that, in the event any unpaid balance, including principal, interest and late fees, is placed with, or referred to, a collection agency, attorney or other third party collection service for collection, a fee of 35% of the unpaid balance shall be added to the unpaid balance due from Consumer – (authorized percentage collection fee). By initializing here, consumer acknowledges and declares that he, or she, knows and understands the above provision, either upon the same having been explained to him or her or having the opportunity to discuss it with Creditor, and he or she agrees of his or her own accord to the above provision.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Today's Date