AUTHORIZATION TO TREAT and PAY BENEFITS TO MEDICAL CARE PROVIDER

I HEREBY GIVE PERMISSION FOR DAVEY SUH, D.P.M., HIS ASSOCIATES OR ASSISTANTS TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY FOOT AND/OR ANKLE CONDITION.

I, THE UNDERSIGNED, HEREBY AUTHORIZE PAYMENT DIRECTLY TO DFW FOOT AND ANKLE, P.A. FOR PROFESSIONAL SERVICES RENDERED.

FINANCIAL STATEMENT

I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO BILL MY INSURANCE COMPANY UNDER THE TERMS OF MY POLICY. HOWEVER, IN THE EVENT OF A DENIAL FOR SERVICES RENDERED, I SHALL BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCES. I FURTHER AGREE TO PAY ANY CO-PAYMENT, DEDUCTIBLE, CO-INSURANCE AND/OR PAY ANY AND ALL UNCOVERED SERVICES. ALL ACCOUNTS, REGARDLESS OF COVERAGE, ARE DUE (IN FULL) SIXTY (60) DAYS AFTER THE DATE OF TREATMENT. AS A CONVENIENCE, WE ACCEPT VISA, MASTERCARD AND DISCOVER.

WE WILL BE GLAD TO PRE-CERTIFY YOUR SURGICAL AND MECHANICAL TREATMENT (ORTHOTICS) AHEAD OF TIME WITH YOUR INSURANCE CARRIER.

OUR OFFICE WILL NOT FILE SECONDARY INSURANCE CLAIMS; THEREFORE, THE PATIENT WILL BE BILLED AND REQUIRED TO SEEK REIMBURSEMENT FROM THEIR SECONDARY CARRIER.

PLEASE CHECK THE BOX BELOW THAT APPLIES TO YOU:

___ HMO, PPO, POS

All co-payments shall be made at the time of your visit. You may be required to pay your bill in full if deductibles are part of your plan.

If a referral is needed, we must have it at the time of your appointment. It is your responsibility to obtain the referral. If you do not have your referral at the time of your appointment, you may do one of two things: 1) Reschedule the appointment, or 2) pay your bill in full. We suggest that you call our office a day or two before your appointment to be sure we have received your referral. If you referral states a specific problem, the doctor is only allowed to treat that problem. Any other problems will require a separate referral. These are not our rules but those of your insurance carrier and/or plan.

___ NO INSURANCE or THIRD-PARTY INSURANCE

Payment in full is due at the time the services are rendered. Please discuss any financial problems you have with the Office Manager before you see the doctor.
A receipt will be given to you to file claims with a third-party insurance carrier.

DATE:________________________

Your signature signifies that you have read and understand all of the above.

________________________ PRINT NAME

________________________ SIGNATURE OF PATIENT AND/OR LEGAL GUARDIAN