ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have/has insurance coverage and I assign directly to Twin Rivers Podiatry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient / Responsible Party Signature ____________ Relationship ____________ Date ____________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Twin Rivers Podiatry for any services furnished me by that 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 understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient / Responsible Party Signature ____________ Relationship ____________ Date ____________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I acknowledge that I have received a copy of Twin Rivers Podiatry's Notice of Privacy Practices. This notice describes how Twin Rivers Podiatry may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights I may have regarding my protected health information.

Patient / Responsible Party Signature ____________ Date ____________

Relationship to Patient ____________

Please Print Patient's Name ____________