AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information necessary to process any claims for services provided to me by Apple Hill Podiatry Associates, P.C. I request payment of this claim and, if the payer accepts assignment, I authorize Payment is made directly to the physician or supplier for the services rendered.

_____ _____

PATIENT OR AUTHORIZED SIGNATURE TODAY'S DATE

PRIMARY INSURANCE

Policy Subscriber

NAME_____ MARITAL STATIS: S M W D SEX: M F

ADDRESS_____CITY _____STATE _____ZIP_____

HOME TELEPHONE #_____ BIRTHDATE_____ AGE_____

SOCIAL SECURITY #_____ EMPLOYER_____ WORK#_____

EMPLOYER ADDRESS _____

SUBSCRIBER EMPLOYMENT STATUS:

STUDENT_____ FULL TIME EMPLOYED_____NOT EMPLOYED_____

PART TIME EMPLOYED_____ SELF EMPLOYED_____RETIRED_____

IS THE POLICY SUBSCRIBER: PATIENT_____SPOUSE_____PARENT/GUARDIAN_____OTHER_____

INSURANCE COMPANY NAME_____

ADDRESS_____TELEPHONE #_____

GROUP NUMBER_____ INSURED ID# OR POLICY NO. _____

Do you have a COPAY (yes/no)? _____COPAY office visit amount? _____

Do you have a COINSURANCE % PAYMENT (yes/no)? _____COINSURANCE_____

SECONDARY/OTHER INSURANCE

Policy Subscriber:

NAME_____ MARITAL STATUS: S M W D SEX: M F

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME TELEPHONE # _____ BIRTHDATE_____ AGE_____

SOCIAL SECURITY #_____ EMPLOYER_____ WORK #_____

EMPLOYER ADDRESS_____

SUBSCRIBER EMPLOYMENT STATUS:

STUDENT_____ FULL TIME EMPLOYED_____ NOT EMPLOYED_____

PART TIME EMPLOYED_____ SELF EMPLOYED_____ RETIRED_____

IS THE POLICY SUBSCRIBER: PATIENT_____SPOUSE_____PARENT/GUARDIAN_____OTHER_____

INSURANCE COMPANY NAME_____

ADDRESS_____ TELEPHONE #_____

GROUP NUMBER_____ INSURED ID# or POLICY NO._____

Do you have a COPAY (yes/no)? _____COPAY Office Visit Amount? _____

Do you have a DEDUCTIBLE (Yes or No)? _____DEDUCTIBLE Amount? _____

Do you have a COINSURANCE % PAYMENT (Yes/No)? _____COINSURANCE %_____

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