CALO Foot & Ankle Specialists, PLLC

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Board Certified in Foot Surgery

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713-987-7791 F: 713-668-8500

Date: _____ D.O.B: _____

Name: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with and assign directly **to CALO Foot& Ankle Specialists, PLLC.,,** all benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance***. I hereby authorize the use of this signature on all my insurance submissions.*** **Initials: _____**

TREATMENT AUTHORIZATION

I authorize **CALO Foot& Ankle Specialists, PLLC.,** to give me reasonable and proper medical care by today's standards.

LAB/INSURANCE CONSENT

I authorize **CALO Foot& Ankle Specialists, PLLC.,** and give my consent to submit blood specimens (blood, tissue, etc.) To the lab(s) of choice for analysis and study to include submission for payment to my insurance company and/or me for charges incurred and agree to full responsibility and payment of non-covered medical services.

RESPONSIBILITY PARTY AGREEMENT

I, _____, guarantor of this account, agree to pay the balance due. Should the collections department need to contact me regards to this account and are unable to reach me by mail or home phone, then I may be reached at my work phone.

_____
Signature

_____
Date

MEDICAL AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to **CALO Foot& Ankle Specialists, PLLC.,** for any services furnished to me by physicians on this group. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand my signature request 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 claim forms or electronically submitted claims, my signature authorizes releasing of information of the Medicare carrier as full charge, and the patient is responsible only for the deductible, co-insurance and non-covered service. Co-insurance and the deductible are based upon the charge determined of the Medicare carrier.

Print: _____

Signature: _____

Date: _____