SUHA KASSAB D.P.M
Medical & Surgical Foot Specialist

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I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Insurance

Primary: _____ Secondary: _____

I authorize use of this form on all my insurance submissions.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original

I agree to pay all deductibles, co-payments, and non-covered services at the time of service unless payment arrangements are made.

Financial Policy

Your insurance policy is a contract between you and your insurance company. We agree to submit, on your behalf, our billing statements to your insurance company. Some insurance companies do not fully cover podiatry benefits; in this event you may be responsible for some or all of our charges. I have read and understand this financial policy and agree to its terms.

Print Name: _____

Signature: _____ Date: _____

Parent or Guardian Signature (if patient is a minor) _____