CONSENT FOR TREATMENT

The above information is correct to the best of my knowledge and I consent to such diagnostic procedures (including x-rays) and medical care and treatment as deemed necessary.

Date ______________________________

______________________________ Signature of Patient or Consentor

______________________________ Witness

Blood Pressure ______________________________

Check Chart ______________________________
(Initials)

THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER OUTSTANDING BALANCE AFTER INSURANCE PAYMENT(S). PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS THIS OFFICE IS SUBMITTING SERVICES ON YOUR BEHALF.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of any medical information necessary to process this claim. A photocopy of this assignment is authorized to be used in place of the original.

I request that payment of authorized benefits be made either by me or on my behalf to "A FOOT ABOVE PODIATRY, INC." for any services provided to me.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

DATE: ______________________________ SIGNATURE: ______________________________