Michigan Foot & Ankle Institute
586-228-2255

Welcome to our office

Release of Insurance Information/Authorization for Payment to Physician/Consent to Treat

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

MEDICARE AND MEDICAID

I, ___________________________________, certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Signature: ____ Date: _________________________

ALL OTHER INSURANCE

I, ___________________________________, hereby authorize Michigan Foot & Ankle Institute to submit a claim to my insurance carrier or its intermediaries to issue payment check(s) direct to the physician(s) rendering the covered services for the next 12 month period.

I authorize Michigan Foot & Ankle Institute to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered.

I further agree that I am responsible for paying any balances which remain after insurance payments have been made.

Signature: ____ Date: _________________________

CONSENT TO TREAT

I, ___________________________________, consent to treatment for myself/my child (if patient is a minor)

Signature: ____ Date: _________________________