William D. Fishco, DPM, PC

AUTHORIZATION & ASSIGNMENT OF BENEFITS

****YOUR INSURANCE MAY NOT PAY FOR ROUTINE SCREENING****
****APPROPRIATE SCREENING DIAGNOSES MUST BE PROVIDED WHEN INDICATED****

Services Provided

- I certify the accuracy of the information I have provided to William D. Fishco, DPM, PC including the information on the applicable insurance benefits page.
- I hereby request that my insurer make payment either to me or, on my behalf, to the company providing services as it pertains to me being treated and receiving medical care by William D. Fishco, DPM, PC.

Disclosure of financial Interests

I acknowledge I may receive services for medical care by my practitioner. I understand Dr. Fishco may have financial interests for services provided to me. I understand that there are alternative options available should I decide not to utilize the services provided to me.

I understand I have the option of using any other facilities of my choice. I understand Dr. Fishco will not treat me any differently if I chose to use another facility.

Payment of Out of-Network Providers

- I understand that some services and or facilities may not be members of My Insurer's network and I am financially responsible for charges, whether or not paid by My Insurer regarding my responsibility of copayments and/or deductibles.

- If My Insurer provides a check to me in payment for the services described above, I shall endorse the check and forward it to the company and/or facility that provided me with services within 30 days of receipt. I understand my failure to do so could result in my account being forwarded to collection agency and reported to a credit bureau.

This Authorization and Assignment shall remain effective until revoked by me in writing addressed to
William D. Fishco, DPM, PC
A photocopy of this Authorization and Assignment shall be as valid as the original.

Print Name:_____ **Date of Birth:**_____

Signature:_____ **Date:**_____