SCOTT W. BERNEBURG, DPM, INC.
dba BECKLEY FOOT & ANKLE CLINIC

PATIENT NAME: ____

INSURANCE ASSIGNMENT & RELEASE, MEDICARE & MEDIGAP AUTHORIZATION & TREATMENT CONSENT

I certify that I have insurance coverage as provided and assign directly to Dr. Berneburg all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Berneburg may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Scott W. Berneburg for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicaid and Medicare Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services. I hereby consent and give my permission to Dr. Berneburg to administer and perform such procedures upon me as he deems necessary.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received Beckley Foot & Ankle Clinic's Notice of Privacy Practices and I have been provided an opportunity to review it.

FINANCIAL POLICY

I have received Beckley Foot & Ankle's Financial Policy and I have been provided an opportunity to review it.
I acknowledge and agree to the terms contained therein.

My signature below attests to the agreement and acknowledgement for each of the above referenced practice matters of insurance assignment and release, insurance authorization, treatment consent, notice of privacy practice acknowledgement and the financial policy.

____ ____________________

Signature of Patient, Beneficiary, Guardian or Personal Representative Date

____ ____________________

Please print name of Patient, Beneficiary, Guardian or Representative AND Relationship