# Foot HealthCare of Delaware

615 W. 18th Street  Wilmington, DE  19809  302-765-2505

## FOOT CARE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize Dr. Gina M. Freeman to provide podiatric medical care to

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*Patient's Name*

I request that Payment of authorized Medicare benefits be made on my behalf to Dr. Gina M. Freeman for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing of the information to the insurer or agency shown. This assignment will remain in effect until revoked by me in writing.

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*Patient's Signature*

## NON-COVERED SERVICE WAIVER

Medicare and some other insurance policies do not reimburse payment for routine foot care. This includes cutting of toenails and trimming of corns and calluses.

I have been advised and I understand that Medicare may deny reimbursement for certain services as not covered. I agree to be fully responsible for the payment of such non-covered services.

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*Patient's Signature* *Date*