New York Foot Group L.L.P

512 Seventh Avenue Ste, 1404
New York, NY 10018

SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions.

I authorize the release of information to all my insurance companies.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

Name_____ Medicare #_____
(If Applicable)

Signature_____ Date_____

I understand that on occasion my insurance company may send reimbursement checks for services rendered by doctors of the New York Foot Group directly to me as opposed to the doctor. I agree if I receive such checks that I will endorse them and bring them to New York Foot Group.

Signature_____ Date_____