DuPage Foot & Ankle
1525 North Main Street • Wheaton, IL 60187
Tel. (630) 538-3668 • Fax (630) 480-7423
www.DuPageFootAndAnkle.com

Authorization for Treatment and Release of Medical Information

AUTHORIZATION FOR TREATMENT

I the undersigned hereby authorize **DuPage Foot & Ankle/Don Nichols, DPM** to render treatment and/or therapy to myself that he deems medically necessary in order to treat the condition(s) I have requested from him and his staff**.**

SIGNATURE OF PATIENT/GUARDIAN:_____

RELATIONSHIP OF GUARDIAN TO MINOR CHILD:_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly to **DuPage Foot & Ankle/Don Nichols, DPM** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and if outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE OF PATIENT/GUARDIAN:_____

RELATIONSHIP OF GUARDIAN TO MINOR CHILD:_____