Eastern Shore Foot Center

Patient's Insurance Authorization:

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed provider below. My signature authorizes payment of all major medical and /or surgical benefits to which I am entitled from the listed insurer below to pay the listed provider assignee. I further authorize the assignee to release all medical and /or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of a any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Patient's Name (please print)

_____

Patient's Signature

_____

Patient's Insurance Company Name:

_____

Patient's Insurance Policy Number:

_____

Patient's Group Policy I.D.

_____

DATE:_____