Financial Acknowledgement and Agreement - Medicare

This document is to inform you that we are contracted with Medicare and will bill Medicare for services rendered. If you have a supplement to Medicare, please provide us with this information and your supplement will be billed as well.

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Paul V. Ledesma, DPM. I also authorize the release of any medical or other information necessary to process a claim. To submit a claim to your insurance carrier, there must be complete patient and insurance information on file.

_____Date_____

Signature of Responsible Party

HIPAA Acknowledgement

I have been presented with a copy of the Centers Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information.

_____
_____
_____

_____Date_____

Signature of Patient

If not signed by the patient, please indicate relationship to patient._____

Signature_____Date_____