Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to UNITED FOOT & ANKLE INC, CHRISTINE NASHED, DPM and/or JOHN BOULOS, DPM, for any services furnished by their physicians. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefit payable for related services.

_____ _____

Signature of Patient Date

Assignments of Benefits

ASSIGNMENT OF BENEFITS TO PHYSICIAN: I hereby assign all medical and/or surgical benefits, to which I am entitled including Medicare, private insurance and any other health benefit plan to UNITED FOOT & ANKLE INC, CHRISTINE NASHED, DPM and/or JOHN BOULOS, DPM. I understand that I am financially responsible for the charges not covered by this authorization or insurance. I hereby authorize UNITED FOOT & ANKLE INC, CHRISTINE NASHED, DPM and/or JOHN BOULOS, DPM to release any information relative to medical care received by me.

_____ _____

Signature of Patient Date

HIPAA Compliance Acknowledgement

Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

_____ _____

Signature of Patient Date