NINA L. COLETTA D.P.M, P.A
INSURANCE REGISTRATION

1. **ASSIGNMENT AND RELEASE:**

I, the undersigned, have insurance and assign the payment directly to Nina L. Coletta D.P.M, P.A for all insurance/medical benefits, if any, and otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to rescue the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient Signature: _____ Date: _____

2. **MEDICARE AUTHORIZATION:**

I request that payments of authorized Medicare benefits be made either to me or on my behalf to Nina L. Coletta D.P.M, P.A for any services furnished me by that physician, I authorized any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on any claims, my signature authorizes release of the information to the insurer or agency shown. Certain services may not be covered or fully reimbursed by Medicare. I authorize the doctor to proceed with the services whether or not covered by Medicare. If Medicare denies payment, I agree to be personally and fully responsible for payment. In in Medicare assigned and covered cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. The patient that case is responsible only for the deductible, coinsurance, and non-covered services.

Signature: _____ Date: _____
Name of Beneficiary: _____ Policy # _____

3. **PEDIATRIC ASSIGNMENT AND RELEASE:**

I certify that my minor/child is covered by the insurance on the front page and assign it directly to Nina L. Coletta D.P.M, P.A all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Parent/Guardian Signature: _____ Date: _____

4. **MEDICAL ASSISTANCE:**

My signature certifies that I received the services submitted. I understand that payment for this service or item will be from federal or state funds, and that any false claims, statements, documents, or concealment of material may be prosecuted under applicable federal and state laws.

Patient Signature: _____ Date: _____