Steven F. Berkey, DPM Podiatrist-Foot Specialist
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INSURANCE AUTHORIZATION AND ASSIGNMENT: **I, the undersigned, hereby assign and convey all insurance reimbursement of authorized Medicaid/Medicare/Medicare Supplement/Medicare Secondary/Any Other Insurance Company benefits to Steven F. Berkey, DPM for any services furnished to me by Dr. Berkey. I authorize Dr. Berkey to release any medical information to the Health Care Financing Administration/Other Insurance Company and its agents in order 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. With respect to Medicare/Medicare Supplement/Medicare Secondary/Other Insurance Company assigned cases, the physician agrees to accept the approved charge and the patient is responsible for only the deductible, coinsurance, co-pays and any non-covered services. Coinsurance, deductibles and co-pays are based upon the charge determination of Medicare/Medicare Supplement/Medicare Secondary/Other Insurance Company. Note: 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.**

AUTHORIZATION TO RELEASE INFORMATION: **I authorize Dr. Berkey to release any information to the Social Security Administration and its intermediaries, insurance carriers or other governmental offices if needed for this or related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record and information related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record to my Health Plan Administrator, its agents and representatives, insurance carrier or its authorized agent, for the purpose of conduction, concurrent or retrospective, of medical review of treatment and services provided at the offices of Steven F. Berkey, DPM. I hereby authorize any plan administrator or fudiciary, insurer to release to Dr. Berkey any and all plan documents, insurance policy and/or settlement information upon written request from Dr. Berkey. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I understand that duplicate copy of this authorization may be used and is as acceptable as the original and may not be revoked unless a request is submitted by me in writing. I hereby give my permission to Steven F. Berkey, DPM to administer treatment; and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.**

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our "Notice of Privacy Practices" policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

Signature _____**Date**_____
Patient/Guardian

Relationship of Guardian To Minor Child:_____