Gary Evans, DPM, FACFAS James Korponay, DPM, FACFAS
One Penn Plaza, Suite 1707, New York, New York 10119

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS INCLUDING MEDICARE AUTHORIZATION , IF APPLICABLE.

I, the undersigned have insurance with ______________________________ Insurance company and assign directly to Dr. Evans/ Dr. Korponay for all medical benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges including copay, coinsurance, and deductible whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient/Guardian Signature: Print Patient Name:

__________________________________ __________________________

Date ________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practice and I have been provided an opportunity to review it.

Name ______________________________________ Birthdate ______________________

Signature ____

Date ____