Richard M. Foltz, MD

NORTH BROWARD NEUROSPINAL SURGERY

FINANCIAL RESPONSIBILITY

nsurance Benefits: I, the undersigned, hereby authorize North Broward NeuroSpinal Surgery to release any information acquired in the course of ny examination and/or treatment to Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers, any nformation needed for Medicare, MEDIGAP, or other insurance claims. I permit a copy of this authorization to be used in place of the original nd I request payment of medical insurance benefits either to myself or to the party who accepts assignment. This is a lifetime authorization. I gree to pay in full for all medical services rendered by North Broward NeuroSpinal Surgery. If I fail to pay any charges, I agree to pay the cost f collection, including reasonable attorney fees.

HEALTH INSURANCE INFORMATION

nsurance Carrier Name:_____ Subscriber Name:_____

ubscriber Date of Birth: _____/_____/_____ Subscriber Social Security: _____/_____/_____

atient Relationship to Subscriber:_____

ASSIGNMENT OF BENEFITS

, the undersigned, whose name appears below, hereby assign all medical and surgical benefits, to include major medical benefits to which I am ntitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue ayment check(s) directly to North Broward NeuroSpinal Surgery for medical services rendered to myself and/or dependents regardless of my nsurance benefits, if any.

CONSENT FOR TREATMENT

, the undersigned, whose name appears below, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or dvisable in the judgement of the attending physician.

AUTHORIZATION TO RELEASE INFORMATION

, the undersigned, whose name appears below, hereby authorize North Broward NeuroSpinal Surgery to:

1. Release any information necessary to insurance carriers regarding my illness and treatments.
2. Process insurance claims generated in the course of examination or treatment.
3. Allow a photocopy of this assignment is to be considered as valid as the original and may be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

have requested medical services from North Broward NeuroSpinal Surgery on behalf of myself and/or my dependents, and I understand that by naking this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further nderstand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon resentation of the appropriate statement.

_____ _____/_____/_____

atient Signature Date

1 West Sample Road, Suite 209
Pompano Beach, Florida 33064
(954) 953-4599/(954) 657-8153