BRADENTON PODIATRY CENTER
3003 26th Street West
Bradenton, FL 34205
(941) 753-1234

ELLENTON FOOT CLINIC
7210 US Hwy 301 N
Ellenton, FL 34222
(941) 729-5588

James B. DiVincenzo, D.P.M.
Ramdin V. Sammy, D.P.M

_____ _____
Patient Name (please print) Patient's Social Security Number (Last 4 digits only)

- **MEDICARE LIFETIME SIGNATURE AUTHORIZATION and CERTIFICATION FOR PAYEMNT**

I certify that the information given by me in applying for payment under Title XVII of the social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

- **OTHER INSURANCE AUTHORIZATOIN**

I have been advised by the Bradenton Podiatry Center's staff that they do participate with my insurance company. We will accept assignment for your services. This means the insurance check will go to our office. I will be responsible for the copay, deductible, and any portion of the bill my insurance company states that I am responsible for. I have been informed that if my insurance company denies this claim for any reason, such as pre-existing conditions, lack of medical necessity, or non-covered services, I will be responsible for the entire bill.

- **SELF PAY**

I have been advised by the Bradenton Podiatry Center's or Ellenton Foot Clinic's staff that they do not participate with my insurance or that I do not have insurance. This means that I will be responsible for any charges that may occur and that payment is due at the time of service.

Signature of Patient_____ _____
Date

By_____

Title or Relationship_____

Consent for Treatment of a Minor

I hereby authorize Bradenton Podiatry Center or Ellenton Foot clinic to administer treatment as they so deem necessary to my son/daughter.

Signature of Parent or Guardian_____ Date_____

Printed name of Parent or Guardian_____

Parent Social Security (Last 4 digits) _____

Signature of Witness_____ Printed name of witness_____