NORTHERN OHIO FOOT AND ANKLE SPECIALISTS, LLC

Marc D. Dolce, DPM Kareem R. Dolce, DPM Nicholas A. Brown, DPM

ASSIGNMENT / RELEASE OF TREATMENT:

I, the undersigned certify that I (or my dependent) have insurance coverage stated and assign to the Physician of care 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, and I may be billed for additional costs incurred in the collection of these accounts. I understand that it is my responsibility to know and understand my insurance plan.

I hereby authorize the above named office to release any private health information necessary in treatment, payment of health care operations. I authorize the use of this signature on all insurance claim submissions. I understand I may revoke this release only in writing. I understand that this office does leave voicemail messages if they are unable to contact patients, unless instructed in writing not to do so.

I certify that the information I have provided this office is true and correct to the best of my knowledge.

I give permission to the above Physician and staff to administer and perform such procedures as may be deemed necessary in my diagnosis and/or treatment on this visit as well as subsequent visits.

Signature of Responsible Party: _____ Date: _____

Date of Birth: _____