WILLIAM J. WEISSINGER, D.P.M, D.A.B.P.S.
Foot Surgery

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A CREDENTIAL YOU CAN TRUST

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PATIENT'S INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE THE PROCESSING OF THE MEDICAL INSURANCE EITHER BY ELECTRONIC OR MANUAL METHOD BY THE LISTED PROVIDER BELOW. MY SIGNATURE AUTHORIZES PAYMENT OF ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED FROM THE LISTED INSURER BELOW TO PAY THE LISTED PROVIDER ASSIGNEE. I FURTHER AUTHORIZE THE ASSIGNEE TO RELEASE ALL MEDICAL AND /OR INSURANCE CLAIM INFORMATION NECESSARY TO SECURE THE PAYMENT(S). I RECOGNIZE MY FINANCIAL OBLIGATION OF ANY CO-INSURANCE OR DEDUCTIBLE, AND NON-COVERED SERVICES THAT MAY BE REQUIRED. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A COPY OF THIS DOCUMENT IS CONSIDERED AS VALID AS ORIGINAL.

PATIENT'S NAME

_____

PATIENT'S SIGNATURE

X_____

IDENTIFICATION NUMBER

_____

DATE

_____

PROVIDER NAME

WM. WEISSINGER, D.P.M.

PROVIDER ADDRESS

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