



COMPLETE FOOT CARE, LLC

CONSENT FOR TREATMENT:

I GIVE PERMISSION TO DR. NEAL ZOMBACK AND/OR ASSOCIATES TO EXAMINE AND TREAT MY FEET AND/OR TO PERFORM SUCH MINOR SURGICAL PROCEDURES AS MAY BE DEEMED NECESSARY TO THE DIAGNOSIS OF MY FOOT CONDITION.

SIGNATURE _____ DATE _____

SIGNATURE OF FILE:

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO REFERRING PROVIDERS AND TO MY INSURANCE COMPANY, WORKERS COMP CARRIER IF APPROPRIATE. I ALLOW FAX TRANSMISSION OF MEDICAL RECORDS IF NECESSARY.

SIGNATURE _____ DATE _____

ASSIGNMENT OF BENEFITS:

I ACKNOWLEDGE COMPREHENSIVE FOOT CARE AS FILING A CLAIM TO MY INSURANCE CARRIER. I AGREE TO PAY ANY PORTION OF THIS CLAIM WHICH IS CONSIDERED SELF PAY. ALSO, I REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO EXCEPTS ASSIGNMENT.

IF DATE OF SERVICE IS NOT COVERED BY INSURANCE DUE TO YOUR ANNUAL DEDUCTIBLE YOU WILL PAY THE OFFICE DIRECTLY UPON RECEIPT OF PATIENT BILL.

ALSO, PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICES ARE RENDERED IF WE ARE NOT A PARTICIPATING PROVIDER FOR YOUR INSURANCE.

I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES

SIGNATURE _____ DATE _____