NORTH EASTERN OHIO PODIATRY GROUP LLC
CONSENT FOR SERVICES

Consent for Treatment I as the patient or legal guardian of, authorize the **Insurance Carrier** to make checks for medical expenses due me payable to the healthcare provider. I also authorize the release of any information regarding treatment in accordance with the HIPAA Privacy rule to the healthcare provider's agents, business partners and associates as needed with those standards. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by the above Insurance Carriers. I understand that after my primary carrier has paid or rejected payment, I am responsible for the remaining balance and that billing my insurance is done of contractual obligation for participating carriers and is done only as a courtesy for other non-participating carriers.

*** Payment Terms Noted ***

* Please refer to the healthcare provider's complete Financial Policy for full payment terms and disclosures *

*** Delinquent accounts may be referred for third party collection and may be charged for associated collection and attorney/legal fees ***

*** This practice accepts the UCR fee for participating insurance carriers. In the event of two carriers, the higher of the UCR fees will be considered ***

PLEASE PRESENT INSURANCE CARD WITH THIS FORM

X / /

Patient Name/Authorized Representtaive:_____ ***Signature*** _____
Date_____

To update the above information, view your account and make payments online, visit:
www.ncdsinc.com *and click on "Patient Login"*

THE FOLLOWING STATEMENT IS FOR THE MEDICARE BENEFICIARIES ONLY:

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER PHYSICIAN

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CURRENT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCE ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR MEDICARE-COVERED SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT.

PATIENT'S NAME or AUTHORIZED REPRESENTATIVE(PRINT):
_____

SIGN: _____DATE:_____