

## Permission To Bill Insurance And Confirmation Of Privacy Policies Notice

By my signature below, I authorize Advanced Foot-care & Laser Center to act as my agent in helping obtain payment from my insurance company. I authorize payment directly to my doctor and I permit this form to be used as "Signature On File" for all my insurance submissions. I authorize release of any information that is required to obtain payment to my doctor. I understand that I AM RESPONSIBLE for payments to Advanced Foot-Care & Laser Center for charges for the above patient regardless of my insurance coverage. I also understand that In the event my insurance company denies payment, I am responsible for the balance in full. I am aware that I am responsible for any co-payments and/or yearly deductible as specified under my insurance contract.

I acknowledge that a copy of the Notice of Privacy Practices is posted in the office and that I have read (or had the opportunity to read if I so chose) and understood the Notice. A copy will be provided to me at my request.

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Signed

Date