# INSURANCE AUTHORIZATION
# ADVANCED FOOT & ANKLE CARE

**PATIENT NAME** _____

**INSURANCE PLAN** _____

**I REPRESENT THAT I UNDERSTAND THAT MY HEALTH INSURANCE COMPANY HAS AGREED TO PAY FOR SERVICES IN ACCORDANCE WITH THEIR POLICIES,DIRECTIVES AND PROCEDURES.**

**I FURTHER UNDERSTAND THAT NOT ALL SERVICES MAY BE COVERED BY MY INSURANCE PLAN. SHOULD MY INSURANCE PLAN MAKE SUCH A DETERMINATION THAT THEY ARE UNWILLING TO PAY FOR THE SERVICES PROVIDED, I AGREE TO PERSONALLY PAY FOR THE SERVICES AND/OR MATERIAL PROVIDED BY ADVANCED FOOT & ANKLE CARE.**

**I FURTHER UNDERSTAND THAT ADVANCED FOOT & ANKLE CARE SHALL HOLD ME PERSONALLY RESPONSIBLE TO PAY FOR THESE SERVICES SHOULD COVERAGE BE DENIED, DEEMED NOT ESSENTIAL, OR NOT A COVERED SERVICE.**

**ADVANCED FOOT & ANKLE CARE**

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**WITNESS** **PATIENT SIGNATURE**

**DATE**_____