Patient Name:_____ **DOB:** _____

CONSENT TO TREAT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____

PRINTED NAME of Patient, Parent (if under 18), Guardian or Personal Representative

RELATIONSHIP TO PATIENT (*Circle One*) : Self Parent Guardian Personal Representative

_____ _____

SIGNATURE of Patient, Parent (if under 18), Guardian or Personal Representative DATE

INSURANCE ASSIGNMENT AND RELEASE

*****ONLY Complete This Section for Insurance Other Than Medicare / Medigap*****

I certify that I have insurance coverage with _____ and assign directly to **BRANDYWINE FAMILY FOOT CARE / FOOT & ANKLE ASSOCIATES** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named medical practice may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

PRINTED Name of ***SUBSCRIBER*** _____

SUBSCRIBER'S Date of Birth _____

SUBSCRIBER's Relationship to Patient (*Circle One*) : Self Parent Guardian Personal Representative

MEDICARE / MEDIGAP AUTHORIZATION

*****ONLY Complete This Section for Medicare / Medigap Insurance*****

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **BRANDYWINE FAMILY FOOT CARE / FOOT & ANKLE ASSOCIATES** for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____

PRINTED NAME of Beneficiary, Guardian or Personal Representative DATE

RELATIONSHIP to Beneficiary (*Circle One*) : Self Guardian Personal Representative