Foot & Ankle Specialists
Mid-Atlantic

Keeping you on track...For Life!

UPDATE TO PRIOR AUTHORIZATION

Patient's Authorization and Assignment of Benefits: I hereby authorize the processing of my medical insurance either by electronic or manual method by Foot and Ankle Specialists of the Mid-Atlantic, LLC (FASMA), and its management company U.S. Foot and Ankle Specialist, LLC (USFAS). My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered to FASMA. I certify that the information I have reported with regard to my insurance coverage, is correct. I further authorize the release of any necessary information, including medical information, for this or any related claims. I grant permission to contact me via email/text as allowed by the FCC. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked, by me, at any time, in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

Consent for Treatment of Minor Patient in Absence of Parent/Guardian: I certify that I am the parent and/or legal guardian of ______________________. I authorize________________________ to bring my child to office visits with FASMA doctors and to consent to the examination and/or treatment of my child. This authorization is effective until revoked by me in writing.

Consent to Photograph/Film/Video: I authorize the podiatrist and associates or assistants to photograph/ film/ video the site of treatment. Details of the photographing/filming/videotaping have been explained to me in terms I understand. I understand that the photos, films, or videos are the property of FASMA, and I may obtain a copy upon my written request. I agree and authorize the use of the photos, film or video for teaching purposes, which includes being shown to other patients, in the advertisements of FASMA, or to place my photo, film or video on FASMA's professional website. *I am aware that my name and identity will not be disclosed.* I deny consent to use my photo/video/film by initialing here: ____

Signature of Responsible Party: **Date:**
Relationship (if not Patient):