Cho Foot & Ankle Specialists, PLLC

Corporate Landing Medical Center
1232 Perimeter Parkway
Virginia Beach, Virginia 23454
(757) 427-7447

Carrie T. Cho, D.P.M., FACFAOM
David J. Cho, D.P.M., FACFAS

Patient Responsibility Agreement Form

Patient Name: _____

Date of Birth: _____

INDIVIDUAL'S FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event, my health plan determines a service to be "non-covered", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I hereby authorize and direct payment of my medical benefits to ***Cho Foot & Ankle Specialists, PLLC*** on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE RECORDS:

I hereby authorize ***Cho Foot & Ankle Specialists, PLLC*** to release to my insurer, government agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

MEDICARE REQUEST FOR PAYMENT:

I request payment of authorized Medicare benefits to me or on my behalf for any services rendered to me at ***Cho Foot & Ankle Specialists, PLLC***, I authorize any holder of medical or other information about me to release to Medicare and its agents, any information needed to determine these benefits or benefits for related services.

By signing below, I hereby acknowledge that I have completely read and fully understand the guidelines and policies set in place by ***Cho Foot & Ankle Specialists, PLLC*** stated above in the Patient Responsibility Agreement Form.

Signature of Patient: _____

Date: _____

Authorized Representative: _____ **Relationship:** _____