PAUL F. BREZINSKI, D.P.M.,P.C.
MEDICAL AND SURGICAL TREATMENT OF THE FOOT AND ANKLE

317 E. DUNDEE RD.
PALATINE, IL 60074
847-359-5550

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree to give my consent for the practice of Dr. Paul F. Brezinski, D.B.A., Paul F. Brezinski, D.P.M., P.C. to furnish foot and ankle services considered necessary and proper in diagnosing and treating my condition.

Patient/Guardian_____ Date_____

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, the undersigned, do hereby assign all medical benefits to which I am entitled, including Medicare, private insurance and third party insurance payors to Paul F. Brezinski DPM. P.C. A photocopy of the assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including x-ray records, to secure payment.

Patient/Guardian_____Date_____

FINANCIAL POLICY STATEMENT

We will bill your insurance carrier as a courtesy to you. You are responsible for the entire bill.
If your insurance carrier does not remit payment within 60days, the balance will be due in full from you.
I also understand and agree to pay for services deemed "not covered services" necessary for the diagnosis and treatment of my foot condition.

If any payment is made directly to you for services billed to us, you recognize the obligation to promptly remit same to Paul F. Brezinski DPM P.C.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If two appointments within a 12 month period are cancelled without at least 24 hours notice a $60 fee will be charged.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

Patient/Guardian/Responsible Party_____ Date_____