VICTOR VILLAGONZALO, DPM
PODIATRIST

2255 N TRIPHAMMER RD ITHACA, NEW YORK 14850
TEL: (**607) 257-8877** FAX: (**607) 257-8879**

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Podiatry Services of Ithaca, P.C. and/or its staff to disclose my individually identifiable health information to Centers for Medicare and Medicaid Services and/or private insurance carrrier(s) for Insurance Claim purposes.
Podiatry Services of Ithaca, P.C. will use and disclose my health information in order to obtain payment to the doctor for services rendered to me and allow insurance companies to process the claims.
I request that payment of authorized Medicare, Medicaid and/or Private Insurance Company benefits be made on my behalf directly to Podiatry Services of Ithaca, P.C. for any medical device(s) and services furnished to me.
I understand that this authorization is voluntary and that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that Podiatry Services of Ithaca, P.C. will file my Insurance as a courtesy. Any charges not covered by my insurance including, but not limited to deductibles, co-insurance, co-payments, convenience items, etc. will be my financial responsibility and payment will be made to Podiatry Services of Ithaca, P.C. at the time service was provided. Furthermore, I will be responsible for payment of services if correct insurance information is not given at the time of service.
If Guarantor makes no payment, Podiatry Services of Ithaca, P.C. reserves the right to charge reasonable collection and/or attorney fees necessary to collect any debt.

Patient &/or Insured Signature:_____ **Date:** _____

RELEASE OF INFORMATION

[ ] YES [ ] NO I authorize Dr. Villagonzalo to discuss my medical condition with my primary physician and other physicians as he deems necessary to provide the best possible care.

PLEASE RELEASE MY PODIATRY RECORDS TO:
_____
_____
_____

[ ] YES [ ] NO The information authorized for release may include information considered to be communicable or venereal disease, including but not limited to Hepatitis, Syphilis, Gonorrhea, HIV, and AIDS.

I hereby authorize Podiatry Services of Ithaca, P.C. and its representatives to leave the following information on my answering machine. (Please check or initial all that apply. **If all are acceptable, just check or initial #6 below**)
1._____ Time, date, doctor's name and reason for appointments and/or scheduled hospital procedures
2._____ Statements indicating that laboratory or hospital tests are normal.
3._____ Requests to call your physician regarding results of tests.
4._____ Confirmation that a prescription has been phoned to a pharmacy for you.
5._____ Any billing or insurance issues which may arise.
6._____ **1 thru 5 is OK**

I have read, understood and/or filled out all of the above information. Affixation of my signature below, I hereby **agree** to all of the above.

SIGNATURE _____ **DATE** _____