

COMPLETE FAMILY FOOT CARE CENTER

340 Lumber Street, Suite B
Littlestown, Pennsylvania 17340

Assignment: Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Todd J. Goldberg, DPM, for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medicare benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medicare insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency, electronically, or by mail. In Medicare assigned cases, this office agrees to accept the "charge determination" of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the "charge determination" of the Medicare carrier.

Patient's Name (please print)

X _____

Provider Information

Complete Family Foot Care Center

Dr. Todd J. Goldberg, DPM

340 Lumber Street, Suite B

Littlestown, PA 17340

Patient's Signature

X _____

Patient's Medicare Number

Name of Medicare Insurer

Medicare Policy Number

Date _____