American FOOT & LEG Specialists

"Center For Quality Foot & Ankle Care"

PAUL COLON, D.P.M. • PRAYA MAM, D.P.M. • JEFFREY FLASH, D.P.M. • RODNEY GADSON, D.P.M. • MARIELI COLON, D.P.M. • LOREN COLON, D.P.M

AUTHORIZATION OF PAYMENT

PATIENT_____DATE_____

AUTHORIZATION OF PAYMENT: I hereby authorize and request that payment be made directly to **American Foot & Leg Specialists, PC**, for Major Medical or Surgical Services rendered at American Foot & Leg Specialists, PC.

AUTHORIZATION OF RELEASE INFORMATION: I authorize the release of any medical or other information necessary to process medical claims. I also request payment of Governmental benefits to the party who accepts assignment below.

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Signature of patient or authorized person

I, the undersigned, do hereby acknowledge that I am aware that the attending physician deems the medical services that I receive as "medically neccessary". Some over the counter supplies are **NOT COVERED** under most medical plans. Insurance coverage is not a guarantee of payment. **I understand and agree that I will be responsible for any balances not covered by my insurance plan.**

Any NSF / returned checks will be assessed a $35.00 fee.
In The Event of Default
If your account becomes thirty (30) days past due, 1.5% per month (18% per year) interest will accrue. If you do not pay off your account it will be placed with a law firm for collection action. You will then be liable for the principal, interest and attorney's fees of fifteen (15) percent and all costs of collections.
I have read, understand and agree to the office policies stated above.

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Signature of patient or authorized person

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