Arch City Foot and Ankle, PC.

Dennis M. Timko, DPM

SIGNATURE ON FILE AGREEMENT

PATIENT NAME _____

MEDICARE NUMBER _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Arch City Foot and Ankle PC for any services furnished to me by these physicians/suppliers. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

DATE_____

PATIENT'S SIGNATURE _____

I hereby give my permission to the Physician's of Arch City Foot and Ankle PC to administer treatment and to perform such procedures as may be deemed necessary in the diagnoses/treatment of my ***foot/ankle condition***. I hereby authorize my insurance benefits to be paid directly to Arch City Foot and Ankle PC and the release of information required by third party payers in claim processing and understand that I am financially responsible for any remaining balance.

_____

SIGNATURE (PATIENT/ RESPONSIBLE PARTY)

2325 Dougherty Ferry Rd
#206
St. Louis, MO. 63122
(314) 779-3723

1935 Prairie Dell
Suite #500
Union, MO 63084
(636) 922-3535