AUTHORIZATION FORM

I hereby authorize Dr. Hillary Brunner, DPM and the ancillary providers of Basin Podiatry, P.A. for evaluate and treatment.

I also hereby authorize payment directly to Basin Podiatry, PA for surgical and/or medical services and release of any information requested by my other treating physicians and/or insurance companies necessary to process medical claims.

Insurance is filed as a courtesy for our patients. Any discrepancy in payment of benefits is between the insurance company and the patient. We do not accept assignment from all insurance companies as payment in full. We have no control over what your insurance company terms as "usual and customary" for benefits. If after 60 days we have not had a response from your insurance company, then the patient will be fully responsible for those charges.

Patient/Legal Guardian Date

OUT OF NETWORK AGREEMENT

I have been notified by Basin Podiatry, P.A., that if they are not in the network with my insurance company, they will likely deny payment for healthcare services or pay at a reduced rate.

I am aware and agree to be personally and fully responsible for payment of all services rendered by and physician associated with the office.

Patient Signature (Guardian) Date

Witness Date