

Conway Podiatry Center, P.C.
8020 Myrtle Trace Drive
Conway, SC 29526

Authorization/ Responsibility Agreement

I hereby authorize any insurance company to pay the proceeds of any benefits due directly to:

Conway Podiatry Center, P.C.

A copy of this authorization and agreement shall be considered as an original for insurance purposes.

Print Name _____ Date _____

Patient Signature _____

I have received a written copy of the Office Privacy Policy. I acknowledge and understand that I am responsible for all of the charges for all the services Rendered to me or any member of my family.

Although I have requested the doctor to bill the insurance company on my behalf, I understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangement for prompt payment of the bill.

Patient Signature _____ Date _____