



Lisa Klemeyer, D.P.M.
3859 Bee Ridge Rd.
Suite 103
Sarasota, FL 34233

PATIENT NAME: _____ **DATE:** _____

PATIENT'S DOB: ____ / ____ / ____
 MONTH DAY YEAR

PLEASE SIGN THE APPROPRIATE SECTION(S)

IF YOU ARE COVERED BY MEDICARE:

Lifetime Medicare B Signature Authorization: For services beginning today, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to other billing agents of Aesthetic and Family Podiatry Center any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits, either to myself or to the party who accepts assignment.

Patient Signature: _____

IF YOU HAVE MEDIGAP COVERAGE:

I request that payment of authorized MEDIGAP benefits be made on my behalf to Aesthetic and Family Podiatry Center. I authorize any holder of medical information about me to release to billing agents of Aesthetic and Family Podiatry Center any information needed to determine these benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

Patient Signature: _____

IF YOU HAVE OTHER INSURANCE COVERAGE:

I authorize the release of any medical information necessary to process insurance claims. I further authorize payment of medical benefits to Aesthetic and Family Podiatry Center, Lisa Norman Klemeyer, DPM in the event they file for insurance.

Patient or Authorized Individual's Signature: _____

ALL PATIENTS PLEASE SIGN HERE:

I hereby understand and agree that my records will be retained at the offices of Aesthetic and Family Podiatry Center.

Patient Signature: _____