

**SECTION 1.**  
**INSURANCE INFORMATION**

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Bluegrass Regional Foot and Ankle Associates, PSC (BRFAA) all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize BRFAA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Insurance Provider \_\_\_\_\_ Policy No. \_\_\_\_\_

**Policy Subscriber information (\*if other than patient)**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_ Employer \_\_\_\_\_

**SECTION 2.**  
**MEDICARE AUTHORIZATION (If Applicable)**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Bluegrass Regional Foot & Ankle Associates, PSC (BRFAA) for any services furnished me by this group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap insurer any information needed to determine benefits payable for services from this provider. I understand my signature request that payment be made and authorized releases of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer of agency shown. In Medicare assigned cases, the supplier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**By signing below the patient and/or patient guardian acknowledges they have read and understand sections 1 and 2 (if applicable) above.**

\_\_\_\_\_  
Patient/Guardian Signature \_\_\_\_\_  
Date