Sports Arena Podiatry Group
3405 Kenyon St. Ste. 502
San Diego, CA 92110
619-225-9601

PATIENT NAME _____ DATE _____

NAME OF INSURANCE COMPANY _____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct the above insurance company to pay by check made out and mailed directly to Sports Arena Podiatry Group, Inc. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed any indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of any professional service charge over and above this insurance payment, unless other arrangements have been made. A photocopy of this assignment shall be considered as effective and valid as the original.

Signature X_____ Date _____

RELEASE OF INFORMATION

I hereby authorize the release of any information acquired in the course of my examination or treatment, or any information pertinent to my case, to the insurance companies named above. This information may be necessary in the processing of insurance benefits. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature X_____ Date _____

HMO ELIGIBILITY GUARANTEE

I understand that I am responsible for assuring that a valid, current authorization is on file before obtaining an appointment. If treatment is rendered without this authorization, payment of this visit will be expected when services are rendered.

I _____ hereby certify that I am insured by _____ with my subscriber number as _____. My HMO coverage is administered through Sharp Community Medical Group and became effective on _____. I have chose Dr. James Felfoldi/ Dr. Andrew Felfoldi to be my podiatry provider. I understand that if the above information is not correct regarding the health plan, the medical group, or the effective date, I am liable for all charges and services rendered. Also, if the above is not correct, I agree to pay in full for all services received within 30 days of receiving a bill from the above noted provider.

Signature X_____ Date _____