

**A.A. Podiatry, P.L.L.C.**

**Annik Adamson, DPM, FACFAS\***  
**Podiatric Medicine and Foot Surgery**  
**Fax (703) 822-0899**

**Inova HealthPlex**

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**Alexandria, VA 22310**  
**(703) 822-0895**

**ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE**

I, \_\_\_\_\_ certify that I/my dependent have/has insurance coverage with \_\_\_\_\_ and I assign directly to Dr. Adamson 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 insurance and as agreed to in the A.A. Podiatry Office Financial Agreement. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

**MEDICARE ASSIGNMENT OF BENEFITS AND RELEASE**

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Adamson. I understand my signature requests that payment be made to Dr. Adamson and authorizes release 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 authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier 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.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices to read. I have read or had the opportunity to read the Privacy Practices of A. A. Podiatry. I understand the document.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\*Board Certified by the American Board of Podiatric Surgery  
\*Fellow, American College of Foot and Ankle Surgeons  
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