**WRIGHT PODIATRY, PLLC**

**PHARMACY:**

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**NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:**

BY SIGNING BELOW, I UNDERSTAND I WILL BE RESPONSIBLE FOR ALL BILLABLE SERVICES NOT COVERED BY INSURANCE.

I authorize Wright Podiatry PLLC, to release medical information necessary to claim reimbursement from insurance companies. I assign the claim payment to be made to Wright Podiatry. This authorization may be revoked at any time by written notice.

**RELEASE OF RECORDS:**

I authorize the release of personal health information to the following person(s)_____

**MISSED APPOINTMENT CHARGES:**

Physicians have the authority to charge a patient $50.00 for any appointments that you do not show up for without prior notification to the office. Initials:_____

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Signature of patient or responsible party Date