



Four States Foot Clinic

Matthew B. Richins, DPM

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FourStatesFootClinic.com

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Four States Foot Clinic Assignment of Benefits

I hereby authorize release of information necessary for my insurance company to process my claim. The insurance information provided on the previous page is correct to the best of my knowledge.

I hereby authorize payment directly to Matthew Richins, DPM insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance.

Patient Name (Print) _____

Guardian Name (Print) _____

Patient/Guardian (Signature) _____

Date _____

I also give my permission for Dr. Richins to download any electronic prescriptions that may help in my medical treatment.

Patient Name (Print) _____

Guardian Name (Print) _____

Patient/Guardian (Signature) _____

Date _____