# Four States Foot Clinic

*Matthew B. Richins, DPM, DABPM*

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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, DABPM 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)** ______________________________ **DOB** ______________

**Guardian Name (Print)** ________________________________________________

**Patient/Guardian (Signature)** ____________________________________________

**Date** ______________________