



# Four States Foot Clinic

Matthew B. Richins, DPM, DABPM

2630 Cunningham Ave  
Joplin, MO 64804

Phone: 417-782-7500  
Fax: 417-782-7524  
fourstatesfootclinic.com

## Four States Foot Clinic Assignment of Benefits

### Insurance (Insured information)

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Insured: \_\_\_\_\_

Insured: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Group: \_\_\_\_\_

Group: \_\_\_\_\_

**Patient Relationship to Subscriber:** Self Spouse Child

**Patient Relationship to Subscriber:** Self Spouse Child

I hereby authorize payment for services provided go directly to Four States Foot Clinic, Matthew Richins, DPM, DABPM, for insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance.

I hereby authorize release of information necessary for my insurance company to process my claim.

The insurance information provided is correct to the best of my knowledge.

Patient Name: (Print) \_\_\_\_\_ DOB: \_\_\_\_\_

Guardian Name: (Print) \_\_\_\_\_

Patient/Guardian: (Signature) \_\_\_\_\_

Date: \_\_\_\_\_