



The FootCare Center of Santa Clarita

A Podiatry Group

24355 Lyons Avenue
Suite 105
Santa Clarita, CA 91321
Tel (661) 253-3668 (253-FOOT)
Fax (661) 253-2872

Authorization to release medical records and to pay physician.

I authorize the release of any medical information necessary to process my claims. I authorize my insurance company to pay by check made out and mailed directly to:

Robert J. Abrams, DPM
The Footcare Center of Santa Clarita
24355 Lyons Ave. Ste. 105
Santa Clarita, CA 91321

the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I agree that a photocopy of this authorization may be used in place of the original.

Patient or authorized signature

Patient name (please print)

Date

If you are a member of an HMO, please list. _____

Note: We do not accept HMO's. If you have one, you will be required to pay for your visit at the time of service.

We will be billing your insurance company for your services. If they fail to pay, you are responsible for these charges (a discount may apply). Each case will be handled on an individual basis.

Robert J. Abrams, D.P.M.
Diplomate, American Board of Podiatric Surgery
Diplomate, American Board of Podiatric Orthopedics