Basso Foot & Ankle Clinics

Douglas Basso, DPM

I hereby authorize direct payment of surgical and medical benefits on my behalf to the provider of these services. I understand that I am personally responsible to the physician for charges not covered by my insurance agreement.

I permit a copy of this assignment to be used in place of the original for purposes of billing

I acknowledge that if my insurance requires a referral, whether it be paper or electronic, that I am responsible for getting an up to date and valid referral. I understand that failure to do so may result in my charges being my responsibility and that payment will be due from me directly.

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I herby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition, to use x-ray examination, or photographs as necessary.

I give Dr. Douglas Basso permission to obtain and release medical information to insurance companies and referring physicians. I have read the following and understand and agree to Douglas Basso, DPM's office policy.

Signature of Patient of Legal Guardian

Date