CHARLES A SULESKEY, D.P.M., F.A.C.F.A.S.
Board Certified in Foot Surgery
Diplomat, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons

MEDICARE LIFETIME AUTHORIZATION

Medicare Certification for payment

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

I authorize Dr. Charles A. Suleskey to submit a claim to Medicare for payment and request payment of authorized benefits be made on my behalf to him for any service he furnishes to me.

Initials: _____

SECONDARY INSURANCE CROSSOVERS

I hereby request that payment of authorized secondary benefits be made on my behalf to Dr. Charles A. Suleskey for any services furnished to me by him. I authorize any holder of my medical information to release to Dr. Charles A. Suleskey any information needed to determine these benefits or benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim.

Initials: _____

SELF-PAY/ PRIVATE INSURANCE PATIENTS:

All charges are due and payable at the time of services unless other arrangements have been made in advance with the office manager. We will bill your primary only.

MANAGED CARE/CONTRACTURAL INSURANCE PATIENTS:

Our office will bill your managed care health insurance company. You are responsible to pay any co-pay, unmet deductible or non-covered service.

MEDICARE PATIENTS:

Dr Suleskey accepts assignment with Medicare. We bill both Medicare and secondary insurance. If your secondary insurance does not cover the Medicare deductible or 20% we will ask that payment from you at the time of your visit.

COLLECTIONS:

I understand that failure to pay my account will result in my account being turned over to a collection agency. I agree to any information being released to the agency and to pay all collection costs. This includes but is not limited to agency fees, court costs, attorney fees and any other fee costs for the collection of my account.

I have read the FINANCIAL OFFICE POLICY and agree to accept responsibility as described. I understand that the information received by the insurance company to Dr Suleskey staff is not a guarantee of payment; it is given as a courtesy. I hereby authorize payments of benefits to be made directly to Dr. Suleskey. I also permit release of any information that may be requested by my insurance company.

Signature: _____ **Print Name:** _____ **Date:** _____