# Charles D. Ganime, DPM, FACFAS, CWS

**Diplomate, American Board of Podiatric Surgery**

## Assignment of Benefits and Financial Agreement

Insurance Information

❒ Primary Insurance: _____

Policy #: _____ Group #: _____

❒ Secondary Insurance: _____

Policy #: _____ Group #: _____

❒ Self Pay Payment for services is expected on the day that services are rendered.

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My signature at the bottom of this form authorizes payment for services rendered to myself or my dependant to be made directly to Charles D. Ganime, DPM. I authorize the release of my information to all of my insurance companies. This authorization is valid until I notify the office of Charles D. Ganime, DPM in writing that it is revoked.

I understand that I am responsible for giving the office of Charles D. Ganime, DPM the correct insurance information at the time services are rendered.

I understand that my co-pay must be paid on the day that services are rendered.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that there is a $15.00 fee for all returned checks.

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the proper referral.

**I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, co-insurance, and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and any attorney fees and/or court costs incurred by this office.**

_____

Patient or Patient's Guardian or Legal Representative's Signature Date

_____

Name (please print) of Patient, Guardian, or Legal Representative Relationship to patient (if not self)