FAMILY PODIATRY
OF MARYLAND

I hereby authorize Family Podiatry of Maryland, LLC to apply for benefits on my behalf for covered services rendered by him. I request payment from my insurance company to be made directly to Family Podiatry of MD, LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of this primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Cancellation Policy:
Because Follow-up appointments are mutually agreed upon, I understand that I will, if needed, cancel any follow-up appointments with more than 24 hours in advance. If I do not cancel before 24 hours in advance of my appointment, I understand that I will pay $35 to Family Podiatry of MD, LLC for losing patient-time allotted to me. I will make this payment within 30 days of missing or failing to cancel the appointment.

Signature of Subscriber or Beneficiary:_____

Date:_____

Updated 05/2025