



BARRY C. BLASS, D.P.M.
PODIATRIST – FOOT SPECIALIST

BOARD CERTIFIED IN FOOT SURGERY
AMERICAN BOARD OF PODIATRIC MEDICAL SPECIALTIES
FELLOW AMERICAN ASSOCIATION OF HOSPITAL PODIATRISTS

TOWN 'N COUNTRY PODIATRY CENTER

7926 West Hillsborough Avenue, Suite G
Tampa, Florida 33615
(813) 885-3668

FOOT CARE CENTER OF TAMPA, P.A.

1020 West Hillsborough Avenue
Tampa, Florida 33603
(813) 238-3631

Fax: (813) 882-0291

I understand that Dr. Barry C. Blass' office will be filing my insurance claims by means of computer generated forms.

I authorize the release of any medical information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed: _____ Date: _____

In the event that I do not pay for my treatment in full, I authorize payment of medical benefits to Dr. Blass.

Signed: _____ Date: _____

For persons with a Medicare supplement only:

Name of Beneficiary: _____

Health Insurance Claim Number: _____

Medigap Policy Number: _____

I request that payment of authorized Medigap benefits be made on my behalf to Barry C. Blass, D.P.M. for any services furnished me by Dr. Blass. I authorize any holder of medical information about me to release to _____ (supp insurer) any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

Patient Name (please print): _____ Date: _____

Parent, Guardian or Patient's legal representative: _____

Signature: _____