Fit Feet For Life

Podiatry Group
Administration and Mailing Address
318 Eighth Avenue North
St. Petersburg, FL 33701

Clinical Offices:

Sun City Center, Tampa, Town N' Country **(813) 645-1993**
St. Petersburg, Clearwater **(727) 824-5100**
www.FitFeetFlorida.com **Fax (727) 824-5132**

I request Fit Feet For Life, Dr. Bonnie Sanchez, and/or her associates to provide podiatry services for:

(Print Patient's Name) _____

I understand that the release of my medical and prescription history and information will help me receive the highest level of quality care available. I therefore authorize the release of my medical records both written and electronic including but not limited to my medical history and medication history and prescription benefits from any of my accounts including but not limited to prescription and claims data clearinghouses or other information necessary to provide me with medical/surgical care or process claims for this care. I also authorize images of me to be obtained and generated only for the benefit of my care. These images may or may not contain information that could identify me. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that the payment of the authorized benefits be made on my behalf. I assign the benefits payable for medical service from Medicare and/or any other insurance company be made on my behalf and authorize payments of any benefits to Fit Feet For Life, Dr. Bonnie Sanchez and/or any of her associates. I have reviewed the posted or have received a copy of Fit Feet For Life's Notice of Privacy Practices.

Your Pharmacy: _____
Name of Pharmacy Location City Zip Code

Name: (First, Middle, Last, Suffix): _____

Preferred Name: _____ **Gender:** Male / Female **Date of Birth**: _____

Address: _____
street city state zip code

Telephone: ( ) _____- _____ ( ) _____- _____ ( ) _____- _____
cell home work/other

E-Mail: _____@_____ _____

Authorized Person's Signature:

SIGNED BY:_____**DATE**: _____

Self ____ or Relationship to patient:_____

Print authorized person's name if not self :_____

□ **as verified on file**