Bruce A. Scudday, DPM, FACFAS

Sierra Tower Building
1700 Curie Dr. Suite 4000
El Paso, TX 79902

East El Paso Physicians Medical Center
1400 George Dieter Suite230
El Paso, TX 79936

LIFE TIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION

Patient's Name_____ Insurance Number_____

I request that payment of authorized medical health insurance benefits be made on my behalf to Bruce A. Scudday, DPM, PA for any service furnished me by Bruce A. Scudday, DPM. I authorize any holder medical information needed to determine these benefits payable to relate services.

I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of HCFA-1500 claim form or elsewhere on the approved claim form electronically submitted claims my signature authorizes releasing of the information to the insurer or agency shown.

In medical insurance assigned case, the physician or supplier agrees to accept the charge determination of the medical insurance carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductibles are based upon the charge determination of the medical carrier.

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Patient or Guardian Signature Date