



East Georgia
**Foot & Ankle
Center**

Howard Gale DPM, FACFAS
Diplomate, American Board of Podiatric Surgery

PO Box 2591
Statesboro, GA 30459
www.dr-GALE.com

If you have a question, please ask the receptionist.

YOUR SIGNATURE ON FILE

I authorize Dr. Gale to examine my feet and to do whatever minor procedures are necessary to evaluate my condition.

I authorize the use of this form on all my insurance submissions and authorize East Georgia Foot and Ankle Center, P.C. to act as my agent in obtaining proper reimbursement from my insurance companies.

I authorize payment directly to East Georgia Foot and Ankle Center.

The undersigned whether the patient, the guarantor(s) or both individually obligates himself/herself to pay the account of East Georgia Foot and Ankle Center in accordance with the regular rates and terms of this practice. I understand a late fee of 1.5% will be assessed on past due balances. Should the account be turned over to a collection agency, an attorney, or the court system for the collection, the undersigned shall pay all collection fees, costs of collection, and reasonable collection fees.

I permit a copy of this statement to be used in place of the original.

Patient Name (Printed:) _____

Responsible Party Signature: _____