INSURANCE INFORMATION

PRIMARY INSURANCE INFO

INS. CO. NAME: _____

NAME OF INSURED: _____

INSURED'S D.O.B.: _____

RELATIONSHIP OF INSURED TO PATIENT:
Self Child Parent Spouse Other

SS# OF INSURED: _____

SECONDARY INSURANCE INFO

INS. CO. NAME: _____

NAME OF INSURED: _____

INSURED'S D.O.B.: _____

RELATIONSHIP OF INSURED TO PATIENT:
Self Child Parent Spouse Other

SS# OF INSURED: _____

ACCIDENT INFO: Please complete ONLY if your injury was the result of an accident.

Date of Accident: ____/____/____ WORKERS COMP MOTOR VEHICLE HOME OWNERS OTHER_____

Name of Company: _____ Claim# _____

Address _____ City _____ State _____ Zip Code _____

Phone # (_____) _____ Ext _____ Contact Person _____

Assignment & Release: I, the undersigned certify that I (or my dependent) have the following insurance coverage and assign directly to 'Family Foot & Ankle Care' all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. This includes any non-covered services. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have received the Office Brochure and read and understand the financial policy of this office. I will be billed $10 for each unpaid bill to me other than the initial bill. I understand that there is a 1% monthly finance charge for all charges remaining unpaid more than 90 days. If my account is referred to a collection agency or attorney for collection, I agree to be responsible for a collection fee equal to 30% of the unpaid balance. My signature confirms that I am in full understanding of all of the above.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date

MEDICARE AUTHORIZATION: I request the payment of authorized Medicare benefits be made either by me or on my behalf to 'Family Foot & Ankle Care' for any services furnished to me by the physicians. I authorize any holder of medical information about me to be released to the Health Care Financing administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

POWER OF ATTORNEY: *Is there someone else legally responsible for making your medical decisions?* YES NO

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: ( ) _____

**We will require a copy of the Power of Attorney for our records.*

Authorized Representative:

As Per the HIPAA Privacy Act you may authorize a representative to obtain medical information or discuss your condition with the Doctor or doctors' staff. The representative may be identified by supplying us with the 'code word' designated by you.

Code Word: _____ (mother's maiden name)

_____ _____ _____

Representative Name Birth Date Phone #

This authorization will be effective until the patient revokes this authorization by signing below.

I hereby revoke the person listed above as my authorized representative, effective the date of my signature below or other notification in writing.

_____ _____

Patient Signature Date

THANK YOU FOR YOUR COOPERATION WITH THE COMPLETION OF THIS FORM