Family Foot & Ankle Care, 122 North Church Rd, Sparta, NJ 07871
Philip C. Caswell, D.P.M.

'WELCOME TO OUR OFFICE' Registration Form

- Please PRINT your answers clearly.
- Please give your INSURANCE CARD(S), DRIVER'S LICENSE, & REFERRAL (if applicable) to the receptionist. A COMPLETE ADDRESS IS NECESSARY FOR OUR RECORDS.
- We would like to make your experience in our office pleasant. We prefer to complete all the business aspects of your visit when you first enter the office. We require the following during your visit to our office:
    1. Copayments are collected upon entering the office. There is a $10 fee to bill for forgotten copays.
    2. Please notify us if you have any changes in your insurance coverage.
    3. We require a copy of your insurance cards and referral to process your claim. If you do not have one or more of these items we will be glad to honor your visit. However, full payment is expected at the time of service.
    4. *FYI: If you need to cancel your appointment we require a 24 hour notification.* ***Appointments that are missed and not cancelled prior to 24 hours before the scheduled time are subject to a $50 "No Show" charge.***
    5. ***If you are scheduled for a laser treatment or surgical procedure and do not provide 24 hours notice. You may be subject to a $75 "No Show" charge.***
- Should you have any questions, please do not hesitate to ask for assistance. Thank you.

PATIENT INFORMATION: (Please print)

First Name: _____ Middle Initial: _____ Last Name: _____

Address 1: _____ City: _____ State: _____ Zip Code: _____

(FULL HOME ADDRESS REQUIRED: NO P.O. BOX)

Address 2: _____ City: _____ State: _____ Zip Code: _____

Home Phone ( ) _____Work Phone ( )_____ Cell ( ) _____

Email _____ SS# _____Date of Birth: (including year)_____

____ I would like to receive newsletters/ information via email.
____ I would only like to receive information related to my medical care via email.

Please circle the appropriate answers to the following:
SEX Male Female Marital Status Single Married Legally Separated Divorced Widowed

ADDITIONAL INFO

1. Primary Care Physician: _____
City _____ State _____ Phone# ( ) _____
2. Pharmacy Name: _____
City _____ State _____ Phone# ( ) _____

*DO YOU HAVE A PRESCRIPTION PLAN FOR YOUR MEDICATIONS? YES NO

How did you hear about us? Check all that apply.

___ Radio ___ Newspaper ___ Website ___ Yellow Pages ____ Personal Reference: Name: _____

___ Physician: Name: _____ ___ Other

We appreciate every referral. It tells us that we are providing the care that you deserve and expect.

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: _____

EMPLOYMENT OF THE INSURED Employer: _____

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

Status: (please circle) Full Time Part Time Retired Unemployed Disabled

Student: Full Time Part Time

Patient Employment Employer: _____

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

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 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.

_____ _____
Patient 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.*