Mid-Atlantic Podiatry Assoc.

PATIENT'S NAME: First	Middle	Last	BIRTH DATE	RACE	SEX
HOME ADDRESS:		LANGUAGE	ETHNICITY	BIRTH PLACE	
EMPLOYED BY:	OCCUPATION		HOME PHONE		
PATIENT SOCIAL SECURITY NO.	EMAIL ADDRESS		WORK PHONE		
WHO REFERRED YOU TO OUR OFFICE?		MARITAL STATUS ___ Married ___ Single ___ Divorced ___ Separated ___ Widowed			
IN CASE OF EMERGENCY, CONTACT?	RELATIONSHIP	PHONE			

INSURANCE INFORMATION

NAME		SOCIAL SECURITY NO.	
BIRTH DATE	RELATIONSHIP TO PATIENT	HOME PHONE	WORK PHONE

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD

PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
Ins. Co. Name: _____	Ins. Co. Name: _____
I.D. No.: _____	I.D. No.: _____
Group: _____	Group: _____

PATIENT AUTHORIZATION

I, _____ (Patient name), hereby authorize the doctors to apply for benefits on my behalf for covered services rendered by the practice and request that payments from _____ (Insurance Company) be made directly to the practice. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any other related claim to the above name.

PLEASE NOTE: Services are rendered to you, the patient. Responsibility for payment to this office is with you, the patient not the insurance company. This form has been specifically designed to assist in the completion of your insurance form. Our office, however, cannot accept the responsibility for collecting your insurance claim or negotiating reimbursement schedule.

This authorization may be revoked by either me or the above named carrier at any time in writing. I permit that a copy of this authorization to be used in place of the original.

_____ Signature of Subscriber or Beneficiary

_____ Date

- •1 There is a charge of $25 for missed appointments in the office and a charge of $100.00 for missed appointments in the operating room; that is, appointments that are not cancelled within 24 hours of the scheduled time.
  In order to avoid these charges, please call us to reschedule or to cancel your appointment.
- •2 All insurance co-pays are due at the time of the visit. A $10.00 fee will be added to the patient account when the co-pay is not paid at the time of the visit.
- •3 Any patient account that is sent to collections for failure to pay will have a 30% administrative fee added to the account.

I have read and acknowledge the above information.

_____ Signature

_____ Date