( ) CHANGE OF ADDRESS: Received_____

Old Zip Code _____

2017

New Zip Code _____

Patient Information Form

(Please Print)

Patient's Name_____ DOB_____/_____/_____

Address: _____ Apt/Sp # _____ City, State, ZIP: _____

Home Phone: _____ SS# _____ Sex _____ Marital Status_____

Contact/Caregiver_____Phone_____Facility: _____

Guar./Financial Responsibility_____ Address_____

Phone_____Email Address:_____ Referred by_____

PCP_____Phone_____NPI#_____

PRIMARY INSURANCE ☐ HOSPICE: _____

COMPANY_____ POLICY#_____ GROUP#_____

Address_____City, State, Zip_____

Phone_____Insured Name_____Insured Employer_____

Insured DOB___/___/___ Insured Age_____Insured Home Phone_____SS#_____

Relationship to Patient_____ **INSURANCE CARDS: ( ) YES ( ) NO**

VERIFIED: ( ) YES ( ) NO DATE:_____

( ) I currently DO NOT have a copy of my medicare card. ( ) initials

SECONDARY INSURANCE

COMPANY_____ POLICY #_____

GROUP#_____ AUTHORIZATION #_____

Address_____City, State, Zip_____

Phone_____Insured Name_____Insured Empoyer_____

Insured DOB___/___/___ Insured Age_____Insured Home Phone_____SS#_____

Relationship to Patient_____ **FINANCIAL HARDSHIP LETTER ATTACHED: ( ) YES ( ) NO**

Financial Agreement and Authorization for Treatment

I authorize treatment of the above and agree to pay all fees and charges for each treatment. I do understand the financial responsibility for payment is my responsibility regardless of insurance, **including annual medicare deductibles and copays**. I also hereby assign and authorize any payment to be made directly to **Toe-Tal Family Foot Care Associates.** I authorize the **RELEASE OF PERSONAL MEDICAL RECORDS** of treatment from my primary care physician, from my insurance company, and attorneys in connection with the above assignments. I understand that payment for services are due upon treatment. **You are entitled to a copy of this agreement at the time you sign.**

We reserve the right to charge for appointments cancelled or broken **without** 24 hours notice, as well as a "no show" fee of **$40.00** when the doctors arrive and patient is not home after confirming appointment. We also reserve the right to charge for any surgery cancelled or broken without 72 hours notice.

Patient's Signature_____ **Date**_____

(rev.: 06/17)