

# PODIATRY CENTER PATIENT REGISTRATION

PATIENT NAME \_\_\_\_\_  
FIRST MIDDLE LAST

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ EMPLOYED: YES \_\_\_\_\_ NO \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DATE OF BIRTH: MONTH \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_ DIABETIC DOCTOR \_\_\_\_\_

NEAREST RELATIVE, PHONE NUMBER \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING

YOU TO THIS OFFICE? \_\_\_\_\_

## OFFICE POLICY ON PAYMENT

CO-PAYMENT ON YOUR HEALTH INSURANCE IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. AS A COURTESY, WE WILL BILL BOTH YOUR PRIMARY AND SECONDARY INSURANCE PROVIDED ALL BILLING INFORMATION HAS BEEN SUBMITTED AT THE TIME OF YOUR VISIT. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COVERAGE REGARDING X-RAYS, EXAMS AND MAJOR SERVICES. IT IS IMPOSSIBLE FOR US TO KNOW THE COVERAGE OF ALL INSURANCE PLANS. WE WILL DO THE BEST WE CAN IN RETRIEVING YOUR BENEFITS. HOWEVER, PROVISIONS AND EXCLUSIONS SUCH AS NON-ALLOWED CHARGES, NON-COVERED SERVICES, ORTHOTICS, NOT MEDICALLY NECESSARY SERVICES OR OTHER FACTORS MAY COME INTO PLAY. WE RESERVE THE RIGHT TO CHARGE INTEREST ON YOUR ACCOUNT AT THE RATE OF 1.5% PER MONTH ON ANY BALANCE OF 60 DAYS OR MORE. COLLECTION FEES AND RELATED EXPENSES (INCLUDING ATTORNEY FEES) WILL BE THE RESPONSIBILITY OF THE PATIENT. I AUTHORIZE PAYMENT OF THE MEDICAL BENEFITS TO THE PHYSICIAN HEREIN FOR MEDICAL SERVICES RENDERED. A PHOTOCOPY OF THIS SIGNATURE IS VALID AS AN ORIGINAL. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED FOR THE PROCESSING OF THE INSURANCE FORM.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_