WELCOME TO OUR OFFICE

Insurance: Please present your insurance card to receptionist

Patient Name: Last First Middle	Birth Date: / / Age: Social Security Number:
Primary Insurance Name:	Secondary Insurance Name:
Claims Address:	Claims Address:
City: State: Zip:	City: State: Zip:
Employer or Group Name:	Employer or Group Name:
Plan ID: Group ID:	Plan ID: Group ID:
Insured Name on ID Card:	Insured Name on ID Card:
Policy Holders SS #: Birth Date: / /	Policy Holders SS #: Birth Date: / /
Effective Date: / / Relation to Insured:	Effective Date: / / Relation to Insured:

Personal Information

Home Address:	Employer/School:
City: State: Zip:	Work/School Address:
Home Phone: ( ) Work Phone:( )	City: State: Zip:
Drivers License #: Expires:	Occupation : How Long:
How were you referred:	Male/Female Marital Status: **Married Single Separated Divorced Widow**

Spouse/Parent Information

Name: Last First Middle	Name of Second Parent or Guardian:
Relationship To Patient: Spouse Parent Guardian Other	Relationship to Patient: Spouse Parent Guardian Other
Home Address:	Home Address:
City: State: Zip:	City: State: Zip:
Employer: For How Long:	Employer: For How Long:
Work Address:	Work Address:
City: State: Zip:	City: State: Zip:
Social Security #:	Social Security #:

Direct Payment Assignment and Information

- I/We hereby name as assignee and also instruct and direct my/our insurance company to by pay by check made out and mailed to:

Family Foot and Ankle Centers
9918 Main Street
Fairfax, Virginia 22031

or if my current policy prohibits direct payment to doctors, then I/we hereby instruct and direct my/our Insurance Company to make out check to me and mail as follows:

c/o Family Foot and Ankle Centers
9918 Main Street
Fairfax, Virginia 22031

for the professional or medical expense benefits allowable, and otherwise payable to me/us under my/our current insurance policy as payment toward the total charges for professional services rendered.

- I/We grant the assignee a limited Power of Attorney to sign my/our name, deposit and negotiate any insurance payment received and apply it to my/our outstanding balance. These payments will not exceed my/our indebtedness to the above mentioned assignee, and I/We have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. This Assignment shall remain in effect until canceled in writing by the assignee.
- I/We agree that a photocopy of this Assignment shall be considered as effective as the original.
- In order that the assignee may submit a claim for payment for services covered under my/our policy, I/we give the assignee authorization to release medical, billing and collection information to my/our insurance carrier and visa versa.
- **FOR MEDIC ARE:** I/We authorize any holder of medical information about me/us to release, to the Health Care Financing Administration and its agent, any information needed to determine these benefits or the benefits payable for related services. I/We hereby authorize Medicare to furnish to you any information regarding my/our Medicare claims under Title XVIII of the Social Security Act.

Signature of Policy Holder

X___________________________________Date: / /

Signature of Patient (if other than Policy holder)

X___________________________________Date: / /

Financial Agreement & Authorization For Treatment

- I/We authorize the Doctors and staff of Family Foot and Ankle Centers to treat the patient named on this form and agree to pay all fees and charges for such treatment.
- I/We agree to pay all charges for myself and members of my family per terms of this agreement. Charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date.
- **I/We acknowledge that if any account balance is not paid in full within 30 days the entire account balance will be subject to a MONTHLY FINANCE CHARGE of 1% (Annual Percentage of 12%) .**
- In the event it becomes necessary to refer this acount to an attorney for collection, I agree that I will be responsible for the payment of attorney's fees and costs in the amount of Thirtythree and one-third percent (33 1/3%) of the balance owed.
- It is agreed that payments will not be delayed or withheld because of any lawsuits, liens or insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable. I/We understand that not all services and/or fees are covered by insurance. I/we understand that I/we are responsible for paying all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by my/our insurance. Such payments are due at the time of service or immediately upon presentation of the bill.
- I/we agree that we shall remain financially responsible for the above named patient until I/we notify you in writing to the contrary. This guarantee is continuing even if the actual patient, if a minor reaches the age of majority.
- I/we certify this information is true and correct to the best of my knowledge. I/We will notify you of any changes in my (the patient's) health or the above information.
- This instrument contains the entire and only agreement between the parties and there are no other promises, representations, or warranties, either expressed or implied. The provisions of this agreement shall not be changed or modified except for an instrument, in writing, signed by parties hereto.
- You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ AND AGREED TO THE CONDITIONS SET FORTH ON THIS FORM.

I/We hereby acknowledge the receipt of a copy of these terms and charges and agree to them as stated and referred to herein.

Signed by Patient (Parent must also sign if Patient under 18 years)

X_____________________________ Date:___/___/___

Signed (parent or other legally responsible person)

X_____________________________Date___/____/____

Today, I will pay bill by:

- Cash
- Check
- Credit Card

In the Future, I can pay my bill by:

- Cash
- Check
- Credit Card