McDonough Podiatry, P.A.

WELCOME TO OUR OFFICE

Patient's Name_____ Date_____
First Middle Last

Patient's Address_____
Street Apt. City State Zip

Telephone: Home_____Cell _____Work_____

Date of Birth _____ Sex: F M Age _____ Social Security # _____

Marital Status: S M W D

Spouse's Name, Parent or Guardian Name if a Minor _____

_____
Phone # Relationship

Name and Address of Person Responsible for Account_____

Patient's Employer_____
Name Address
Occupation_____

Name of Insurance Company_____ Policy #_____
Group Name _____ Group #_____
Name of Primary Insured _____ Date of Birth_____

Medicare Number (including letters) _____

Supplemental Coverage_____
Name Address
Policy #_____
Name of Family Physician_____
Whom May We Thank_____

MCDONOUGH PODIATRY, P.A. IS IN COMPLIANCE WITH PRIVACY POLICIES ESTABLISED APRIL 2003. A COPY OF OUR PRIVACY POLICY IS AVAILABLE UPON REQUEST.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE, INCLUDING CO-PAY'S AND DEDUCTIBLES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

Signature_____ Date_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release to Social Security Administration and Health care financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare /Other Insurance Company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare /Other Insurance Company as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare /Other Insurance Company.

Signature_____ Date_____