**PATIENT REGISTRATION FORM:**

*All information provided on this form will remain confidential in compliance with HIPAA guidelines.*

## PATIENT INFORMATION

NAME ______________________________ Male Female

Social Security Number ______________________ Birth Date ______________________

Address ______________________________________________
STREET CITY STATE ZIP CODE

Home Phone ____________________ Cell Phone ____________________ Other ____________________

Are you employed or student (please circle choice) Full Time Part Time

Employer ______________________________________________

Address ______________________________________________
STREET CITY STATE ZIP CODE

Primary Care Doctor ______________________________________________

Address ______________________________________________
STREET CITY STATE ZIP CODE

In the case of an emergency, whom should we contact? ______________________________

Relationship ______________ Home Phone ____________________ Work Phone ____________________

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## RESPONSIBLE PARTY

*(the person who supplies the patient's insurance or who is responsible for payment if uninsured.)*

NAME ______________________________ Social Security Number ____________________

Male Female Birth Date ______________ Relationship to the Patient ____________________

Home Address ______________________________________________
STREET CITY STATE ZIP CODE

Home Phone ____________________ Cell # ____________________ Work# ____________________

Employer Name ______________________________________________

Employer Address ______________________________________________
STREET CITY STATE ZIP

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## INSURANCE INFORMATION: **Please give all cards to the receptionist so we may copy them**

Primary Insurance Company Name ______________________________________________

Secondary Insurance Company Name ______________________________________________

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## REFERRAL INFORMATION

**How did you learn about our practice?**

Primary Care Doctor ____________________ ______________________________
NAME ADDRESS CITY/STATE ZIP CODE

Friend/Relative ____________________ ______________________________
NAME ADDRESS CITY/STATE ZIP CODE

| | | | |
|---|---|---|---|
| SWB Phone Book | Other Phone Book | Insurance Company | Newspaper |
| Television | Radio | Direct Mail | Internet |

**ASSIGNMENT and RELEASE**

I certify that I have insurance coverage as indicated above. I hereby assign directly to *Foot & Ankle Associates* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payment is made by insurance, including, but not limited to, the deductible, copayment, coinsurance, and any noncovered services. I understand that if my account is not paid when due, I will be responsible for all costs incurred during the collections process, including collection fees that are assessed. Co-insurance and deductible are based upon the amount of payment determined by my insurance carrier. I authorize *Foot & Ankle Associates* to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________________________________ ____________________

Signature of Responsible Party/Authorized Representative Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made on my behalf to *Foot & Ankle Associates*, for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requires that payment be made and authorizes release of medical information necessary to pay the claim. If I have health insurance in addition to Medicare, my signature authorizes release of the information to the insurer or agency. In Medicare assigned cases, the physician, or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

____________________________________________ ____________________

Signature of Medicare Beneficiary/ Date
Authorized Representative