WELCOME TO ALLENTOWN FAMILY FOOT CARE

PERSONAL INFORMATION:

Last Name:______________________First Name:_____________________MI____

Street:____

City:_____________________________State:__________Zip:___________________

Phone:(____)____________________Cell Phone: (_____)______________________

Fax(___)________________________Date of Birth:________/________/_______

Social Security #_________________________Marital Status:__________________

Who to Contact in case of emergency:

Last Name:_________________________First Name:__________________________

Relationship:_________________________Phone(____)_______________________

Employment Information:

Employer:____

Street:____

City:__________________________________State:_________Zip:_______________

Occupation:____________________________Phone:__________________________

Who Referred you to our office?______________________________________

Family Physician___________________________Date Last Seen:____/____/____

How and where would you like us to communicate with you about your appointments and treatment? (Please circle choice:

Home Office Cell Other:______________________

Insurance Information: PLEASE PRESENT CARD TO BE SCANNED

Primary Insurance Company_______________________________________

ID#:________________________________Group#:_______________________

Policy Holder:__________________________Date of Birth:____/____/______

Employer____

Copay:________________________ Deduct:_______________

Secondary Insurance Company_______________________________________

ID#:________________________________Group#:_______________________

Policy Holder:_________________________ Date of Birth:____/____/_______

Employer____

Copay:________________________ Deduct:_______________

Do you have a Medical Savings Plan or Health Savings Plan that pays for your deductible or non -covered services? Yes______ No_________

STATEMENT OF INSURANCE COVERAGE. . *I authorize payment of medical Benefits to Allentown Family Foot Care Professional Corporation. I authorize the Doctor to release any information needed to submit and process my claim. In the case Of co-payments, deductibles or non-covered services, I will be responsible for payment.*

Signature:______________________________________ Date:_________________

LIFETIME MEDICARE RELEASE STATEMENT. *I authorize payment of medical Benefits to Allentown Family Foot Care Professional Corporation. I authorize the Doctor to release any information needed to submit and process my claim. In the case Of co-payments, deductibles or non-covered services, I will be responsible for payment.*

Signature:______________________________________ Date:__________________

Email Address for Newsletter:______________________________________

ALLENTOWN FAMILY FOOT CARE PROFESSIONAL CORPORATION
FINANCIAL POLICY

Thank you for choosing us as your podiatric health provider. We are committed to providing you with the highest quality of care. The following is a statement of Financial Policy, which we are required that you read, agree to and sign prior to treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICES. CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICES FOR PATIENTS WITH INSURANCE.
WE ACCEPT CASH, CHECK, VISA/MASTERCARD/DISCOVER.
INTEREST OF 1% IS CHARGED MONTHLY ON ALL BALANCES OVER 60 DAYS.

INSURANCE BENEFITS

Those with insurance benefits please remember that YOUR insurance contract is between YOU, YOUR EMPLOYER and the INSURANCE COMPANY. YOU are responsible for payment regardless of any arbitrary determination by your insurance company of what is usual and customary. If insurance payment is not received within 45 days, then the entire amount becomes due and payable by you immediately. A Pre determination is NOT a guarantee of payment.

MINOR PATIENTS

The adult who accompanies a minor (and the minor's parents or guardians) are responsible for full payment at the time of service.

COLLECTION COSTS

If your account is referred for collection (after 120 days of non-payment) you will be responsible for collection costs in the amount of 30% of the outstanding balance and all court costs and reasonable attorney's fee.

I have read this policy and agree to all contained in it. Patient (or person responsible for account) ____ Date: ___________