

INSURANCE INFORMATION

(Please present insurance cards and forms to the receptionist)

_____			Chart # _____
Patient=s First Name	Initial	Last Name	Office Use
_____			_____
Patient=s Social Security Number			Birth Date

Primary Insurance Information

Primary Carrier Name: _____ Medicare

Claims Address: _____

City State Zip

Phone: (_____) _____

Employer or Group Name: _____ Group Number: _____

Insured Name on I.D. card _____ Insured Birth Date _____

Member Policy ID or Social Security Number: _____

Patient Relationship to insured: Self Spouse Child Other _____

Secondary Insurance Information

Secondary Carrier Name: _____ Medicare Medicaid

Claims Address: _____

City State Zip

Phone (_____) _____

Employer or Group Name: _____ Group Number: _____

Insured Name on I.D. card _____ Insured Birth Date _____

Member Policy I.D. or Social Security Number _____

Patient Relationship to insured: Self Spouse Child Other

The Responsible Parties whose signatures appear below agree as follows:

The Doctor(s), Associate Doctor(s), and staff of Total Foot Care, P.A., hereafter referred to as TFC, are authorized to medically treat the patient named on this form and to exchange past, present and future medical information with the patient=s other medical care givers for the purpose of enhancing and promoting the continuity of care for the patient.

The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement and authorize the TFC or agents thereof to make credit investigations including employment verifications. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until the TFC receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

Not all services and /or fees are covered by the benefits plan of the Responsible Parties= health care insurance, (i.e., insurance company, HMO, employer or government benefits provider) hereafter referred to as the PLAN. **Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill.**

If any account balance is not paid in full within 60 days, the entire account balance will be subject to a **MONTHLY FINANCE CHARGE** and a **MONTHLY COST OF REBILLING/ ACCOUNT MAINTENANCE CHARGE** at the following rates: Your **MONTHLY FINANCE CHARGE IS 1.5% (18% Annual percentage rate).** YOUR **MONTHLY COST OF REBILLING IS \$8.00.** These rates are subject to change upon 30 days written notice.

If any account balance should remain unpaid for 60 days and the TFC refers the account to a collection agency or attorney for collection, the Responsible Parties agree to pay the costs of collection and that such fees and costs may be added to the account balance. In a legal action between the parties to this agreement to collect an unpaid balance due for medical services rendered, the prevailing party shall be entitled to recover reasonable attorney=s fees and costs.

Payments will not be delayed or withheld, regardless of any lawsuits, liens, insurance coverage, the pendency of claims thereon or the outcome of medical treatment. All proceeds from the PLAN are assigned to the TFC where applicable. As they are responsible for all charges the Responsible Parties will assist the TFC in every way to collect payments from the PLAN to the extent their help is required.

The Responsible Parties acknowledge receipt of Total Foot Care=s Financial Agreement & Authorization for Treatment.

Agreed to and accepted by the Responsible Parties:

Signed by First Responsible Party(Patient or, if patient is under 18 years old, Parent, or Guardian; Spouse or other Guarantor

X _____
Date: _____

Signed by Second Responsible Party(if patient is under 18 years old, Second Parent, or Guardian; Spouse or other Guarantor)

X _____
Date: _____

ASSIGNMENT OF BENEFITS

I/ We hereby name Total Foot Care, P.A.(TFC) As my/our assignee. I/We instruct my/our health care benefits plan administrator, i.e. Plan to pay TFC directly for all professional and medical services provided by TFC, through the means of electronic funds transfer(s)(EFT) or by check(s) made payable to and mailed to the TFC.

(For Medicare/Medigap Recipients): A I request that payment of authorized Medicare benefits be made either to me or on my behalf to Total Foot Care, P.A. for any services furnished by that physician or supplier. I authorize any holder of medical information about me released to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.@

AI request that payment of authorized Medigap benefits be made either to me or on my behalf to Total Foot Care, P.A. for any services furnished me by that physician/supplier. I release to _____
(Medigap Insurance Co.)
any information needed to determine these benefits for related services.@

X _____ Date: _____