Please Print Computer Assigned Account No.____________________ Doctor:____________________

PATIENT INFORMATION

Last Name: ____________________ First: ____________________ Middle: ____________________

Street Address____________________ Mailing Address: ____________________

City: ____________________ State:__________ Zip: __________ Phone: ____________________ Sex: M F

Marital Status: S M W D Date of Birth: ____________________ SSN: ____________________

Name of Family Doctor: ____________________ Phone: ____________________

Employer: ____________________ Phone: ____________________

E-mail Address: ____________________ May we e-mail you a reminder of your next appt.? __________

[ ] PARENT / [ ] SPOUSE

Last Name: ____________________ First: ____________________ SSN: __________ Date of Birth__________

Employer: ____________________ Phone: ____________________

Briefly describe your foot condition: ____________________

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How did you hear about our office? ____________________

❑ TV ❑ Radio ❑ Leaf-Chronicle ❑ Todd County Newspaper ❑ Stewart/Houston Times ❑ Clarksville Yellow Pages

❑ Billboards ❑ Friend/Family - Name ____________________ Address ____________________

Emergency Contact: Other than someone living with you

Name: ____________________ Relationship: ____________________ Phone: ____________________

INSURANCE:

1st Insurance: ____________________ Insured: ____________________ SSN: __________ Date of Birth__________

2nd Insurance: ____________________ Insured: ____________________ SSN: __________ Date of Birth__________

SIGNATURE ON FILE

I understand if a referral or prior approval is needed from my insurance that it is my responsibility to obtain it. I am responsible for the charges in full if denied by my insurance company. I request that payment of authorized benefits be made on my behalf to Schussler Foot Care Centers, PLC for any services furnished me by the listed provided/supplier. I authorize any holder of medical information about me to release to my insurance and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In Medicare assigned cases, the provided or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please print) ____________________

PATIENT'S SIGNATURE: ____________________ Date: ____________________

FINANCIAL POLICY:

Full payment is expected at the time services are rendered unless confirmation is received from your insurance company stating your policy benefits. Upon confirmation, we will determine your financial responsibility or portion of your charges that you will need to pay as services are provided. I understand I am responsible for all charges incurred including those my insurance company does not honor or states they are non-covered. Forms of Payment Accepted: Cash, Checks, MasterCard, Visa and Discover. Lab and anesthesia services provided in our office are billed independently by the lab and the anesthetist.

I/WE understand that the physician's services rendered are payable at the time the service is rendered. I/WE understand that failure to pay said invoice upon mailing of notice of payment constitutes a breach of my/our payment agreement. In the event of a payment breach, I/We agree that I/We will be responsible to the physician for a monthly service charge of 2% of the outstanding balance from the date the service was rendered. I/We further agree that I/We agree to pay the physician's reasonable attorney fees, costs of collection, court costs, and pre and post judgement interest (service charge).

SIGNATURE OF PATIENT: ____________________ Date: ____________________

Signature of Guarantor ____________________ Date: ____________________

❑ New Patient Letter Sent __________