FAMILY Podiatry and Vein Care

Medical & Surgical Foot Specialist
500 N. W. 43rd Street, Suite 2
Gainesville, FL 32607 • 352---376---5112
www.gainesvillefootdoc.com

Today's Date: _____

**PATIENT INFORMATION:**

Last Name: _____ First Name _____ MI _____ Birth Date _____

SS#: _____ • Gender: ☐ Male ☐ Female • E-mail: _____

Cell Phone: ____-____-_____ Work: _____-_____-_____ Home phone _____

Patient's Address: _____

City/State/Zip: _____

Employed By: _____ Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widower ☐ Minor

Patient/Parent Driver's License # _____

Spouse/Parent Name: _____ SS#: _____

In case of emergency, contact: _____ Phone _____

Referral: Whom may we thank for referring you to our office? _____

How did you learn about our office? ☐Physician ☐ Friend/Relative ☐Website ☐Insurance Book ☐Other

**Family Physician:** _____ **Phone** _____ **Last Visit** _____

**INSURANCE INFORMATION:**

**Primary Insurance Co:** _____ ID#: _____

Name of insured: _____ SS#: _____ DOB: _____

Relationship to Patient: _____ Employed By: _____

**Secondary Insurance Co**: _____ ID#: _____

Name of insured: _____ SS#: _____ DOB: _____

Relationship to Patient: _____ Employed By: _____

MEDICAL RELEASE: I assign the right to payment for all medical benefits directly to Family Podiatry, PA in consideration for medical services and supplied provided pursuant to my health insurance plan, In the event my health insurance plan refuses to pay for provided medically necessary services, I also assign all of the ERISA rights to Family Podiatry, PA for a full and fair review of any and all denied claims. This ERISA assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of Family Podiatry, PA to see patients, including myself on an insurance assignment basis. I understated that it my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services. I give consent to release medical Information to Family Podiatry, PA. I give consent to Family Podiatry, PA to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to Family Podiatry, PA to send medical Information, as necessary, to my insurance plan. ERISA is an acronym for the Employee ReUrement Income Security AcL The Employee Retirement Security Act Includes federal laws requiring Insurance companies to process submitted insurance claims and appealed (denies) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denies) insurance claims according to the ERISA regulations may result in fines charged to the insurance company In amounts up to $100 a day for each infraction.

Printed Name: _____ Patient Signature: _____ Date: _____