

Welcome to Elgin Foot & Ankle Center!

Please complete this form and provide the receptionist with your insurance card(s) and drivers license or photo ID.

PATIENT INFORMATION

Name: _____ Social Security No.: _____ Sex: M F

E-mail address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Birth date: _____ Marital Status: single married divorced widowed separated

Employer name: _____ Occupation: _____

Due to government requirements, we now must ask for the following information:

Primary Language: _____ Race: _____ Ethnicity: _____

PERSON RESPONSIBLE FOR PAYMENT, IF NOT PATIENT If patient is a minor, please enter responsible party information. (The adult presenting the minor for care is the responsible party. We cannot bill absent parents.)

Name: _____ Social Security No.: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Sex: M F Marital Status: single married divorced widowed separated

Employer name: _____ Work phone: _____ Occupation: _____

Relationship to patient: _____

POLICY HOLDER (if different from the patient or the person responsible for payment)

Policy Holder Name: _____ Social Security No.: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Sex: M F Marital Status: single married divorced widowed separated

Employer name: _____ Work phone: _____ Occupation: _____

Relationship to patient: _____

How did you hear about our practice? (circle one) physician phonebook insurance friend/relative
internet our website other _____

Referring Doctor: _____ **Primary Care Physician:** _____

Pharmacy: _____ **Co-pay mount:** _____

WORKERS COMPENSATION ONLY: Please ask the receptionist for our Workers Compensation form.

Please read and sign the other side.

FOR OFFICE USE ONLY: ENTERED BY: _____ ACCT: _____ DATE: _____

(Welcome form traknet 05/09/11)

TREATMENT CONSENT

I hereby authorize and consent to treatment at Elgin Foot & Ankle Center, S.C. This may include the administration of medication, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis or treatment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to Elgin Foot & Ankle Center, S.C. for any services rendered by the practice subsequent to this date, and for such other charges as may be made by said practice. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that health insurance coverage varies and that not all services provided may be covered. It is my responsibility to negotiate payments from the insurance company and while they use such terms as customary, reasonable, prevailing, usually, etc. to limit their coverage, **payment of the office charges remain my obligation.**

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible unless otherwise specified in another written contract, for all services rendered to the patient. I agree to pay for service rendered, in full at time of service, unless other arrangements are made in advance with this office. Whether or not I have insurance, I as a patient/guarantor am responsible for the charges for services rendered to the patient. I further understand that I will be responsible for any additional charges for services which may not be available at the time of leaving the office. I agree to pay for any attorney fees or collection fees that result of the pursuit of collection for services rendered.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Elgin Foot & Ankle Center, S.C. to release any and all information to insurance companies or associations, employee groups, employer, government agencies or their third party payers and their agents or employees, either by mail or electronically, as may be necessary for the completion of all my claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records.

AUTHORIZATION TO LEAVE MESSAGES

I authorize the staff of Elgin Foot & Ankle Center, S.C. to leave a message on my home voice mail, answering machine or other electronic device, or with a person who answers my home phone in regards to my health, my appointment, or my financial obligations to the practice.

TRANSFER OF CREDIT BALANCE

A credit balance resulting from payment to Elgin Foot & Ankle Center, S.C. from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

I certify that the information provided on the front of this form is correct to the best of my knowledge. I have read and understand the above and duly authorize Elgin Foot & Ankle Center, S.C. and/or its appointees to execute the above and its terms.

Signature patient or legal representative

date