University Foot Associates

1. **INSURANCE – Please Present Your Insurance Forms, Cards, and ID to the Receptionist**

You only need to fill the top part of this form out if the patient is not the cardholder!

Primary Insurance	Secondary Insurance
Patient: First Middle Last	Patient: First Middle Last
Primary Carrier Name:	Secondary Carrier Name:
Cardholder's Name:	Cardholder's Name:
Cardholder's Birth Date: / /	Cardholder's Birth Date: / /
Member policy ID or SS# of Cardholder:	Member policy ID or SS# of Cardholder:
Patient Relationship to Cardholder (circle one)	Patient Relationship to Insured (circle one)
Self Spouse Child Other	Self Spouse Child Other

INSURANCE AGREEMENT: DIRECT ASSIGNMENT & INFORMATION RELEASE

I/ we hereby name Practice Name as my/our assignee. I/We instruct my/our health care benefits plan administrator, ie; insurance company, HMO, employer or government benefits provider, hereafter referred to as the PLAN, to pay Practice Name directly for all professional and medical services provided by Practice Name. Through the means of electronic funds transfer(s) (EFT) or by checks made payable to and mailed to Practice Name. If my current policy prohibits direct payment to doctors, then I/we hereby instruct and direct the PLAN to make out all checks payable to me/us and mail the payments to me/us in care of Practice Name.

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

The Responsible Parties whose signatures appear below agree as follows:

- ❑ The Doctor(s), Associate Doctor(s), and staff of Practice Name, 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 treatments that are incurred by the patient per the terms of this agreement and authorize the Practice Name or agents thereof to make credit investigations, including employment verifications. All charges shown of 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 Practice Name 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-payment, non-covered services, and any portion of covered services not paid in full by the PLAN and understands that such payments are due at the time of service or immediately upon presentation of the bill.

Agreed to and accepted by the Responsible Parties:

For the purpose of obtaining payment for services rendered, I/we give Practice Name, authorization to release and/or exchange medical, billing and collection information.

X____DATE:__________________________