ESSEX UNION PODIATRY REGISTRATION FORM

DATE _____

LAST NAME_____ FIRST NAME _____ MI_____ SEX_____

ADDRESS _____ CITY _____ STATE ___ZIP_____

HOME PHONE (_____)_____ CELL PHONE (_____)_____

EMAIL _____@_____ SOCIAL SECURITY _____

DATE OF BIRTH ___/_____/_____ MARITAL STATUS S M D W (CIRCLE ONE)

IF A MINOR FINANCIALLY RESPONSIBLE PERSON_____

MEDICAL INSURANCE _____ ID_____

EMERGENCY CONTACT PERSON NAME_____ PHONE(____)_____

PRIMARY/REFERRING DOCTOR _____ PHONE (____)_____

PHARMACY NAME _____ CITY _____ STATE _____

Financial Policy Statement

Welcome to Essex Union Podiatry LLP. We are pleased you have chosen our practice for your podiatric care. We are committed to providing you with the highest quality services available. We ask that you carefully read and sign the following policy. We must emphasize that, as your podiatric provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment there of regardless of where services are rendered. If we are contracted with your insurance company, including Medicare, we will accept assignment. You will be responsible for your payment portion at the time of service.

Failure to provide necessary referrals and/ or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibility.

You are responsible for obtaining any referrals and/or authorizations, which your insurance company requires before care is provided. All co-pays are due and payable at the time service is rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payments at the time services are rendered, unless other arrangements are made in advance.

We require 24 hour notice for cancelling appointments in the office and 48 hours notice for surgeries being cancelled. Not notifying the office in a timely manner can result in a $25 charge for office visits, and $100 charge for surgery cancellations.

There is a $35 fee for any checks returned for insufficient funds, over and above bank charges we incur.

In consideration of the services performed by Essex Union Podiatry LLP you agree to abide by the terms of this Financial Statement.

_____ _____

Print name Sign and Date

Patient's Authorization

I, hereby authorize Essex Union Podiatry LLP to apply for benefits on my behalf for services rendered. I request payment from Medicare, and commercial insurances be made directly to Essex Union Podiatry LLP. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

_____ _____

Print Name Sign and Date