



REGISTRATION FORM

DATE _____

FIRST NAME _____ LAST NAME _____ MI _____

ADDRESS _____ APT/UNIT _____

CITY _____ STATE _____ ZIP _____

D.O.B _____ AGE _____ EMAIL _____

SEX: MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED DIVORCED WIDOWED

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

PHARMACY _____ CITY _____ STATE _____

PRIMARY/REFERRING DOCTOR _____ LAST SEEN _____

SOCIAL SECURITY # _____

IN CASE OF AN EMERGENCY:

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

CONTACT PHONE NUMBER (_____) _____

IF PATIENT IS A MINOR:

FINANCIALLY RESPONSIBLE PERSON _____ RELATIONSHIP _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ ARE YOU THE SUBSCRIBER/POLICY HOLDER? YES NO

SECONDARY INSURANCE _____ ARE YOU THE SUBSCRIBER/POLICY HOLDER? YES NO

****IF YOU ARE NOT THE SUBSCRIBER/POLICY HOLDER OF THE INSURANCE:***

SUBSCRIBER/POLICY HOLDER NAME: _____ D.O.B: _____

RELATIONSHIP TO PATIENT: _____ SOCIAL SECURITY # _____

ADDRESS _____ APT/UNIT _____

CITY _____ STATE _____ ZIP _____

IF ADDRESS IS THE SAME AS ABOVE



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.

Patients are responsible for understanding whether their annual deductible has been met. If the deductible has not been satisfied, any applicable charges will be applied toward it by the insurance carrier, and the remaining balance will be the patient's financial responsibility.

We require 24-hour notice for canceling appointments in the office and 48-hour notice for surgeries being canceled. Not notifying the office in a timely manner can result in a \$50 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.

_____ X _____
Patient Name Sign Date

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

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.

_____ X _____
Patient Name Sign Date