Ankle & Foot Centers of Missouri, P.C.

Patient Information

Name _____ Phone (____) _____ SS# _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Male___ Female ___ Single___ Married ___ Widowed ___ Other ___

Email _____ Race/Ethnic Origin (Optional)_____

Employer _____ Employer's Phone (____)_____

Employer's Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone (____)_____

Who may we thank for referring you? _____

Primary Insurance Information

Insurance Company _____ ID# _____Group# _____

Insured's Name _____ Patient's Relationship to Insured _____

Insured's Employer _____ Work Phone (____)_____

Insured's Birth Date _____ Insured's SS# _____

Secondary Insurance Information

Insurance Company _____ ID# _____Group# _____

Authorization for Treatment & Acknowledgement of Receipt of "Notice of Privacy Practices"

I authorize the examination and treatment upon: (Patient Name) _____
be performed by any doctor affiliated with Ankle and Foot Centers of Missouri, P.C.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Signature/ Parent or Legal Guardian _____Date _____

Assignment of Benefits for Commercial/Medicare/Medicaid/Medigap Authorization

The undersigned authorizes the attending doctor to furnish and release to all insurance companies insuring the patient named above, the Social Security Administration and Health Care Financing Administration or its intermediaries any and all information with respect to any illness or injury for which the patient is receiving treatment and related claims. This shall include copies of medical records if requested. I permit a copy to be used in place of the original. I authorize payment of my medical benefits directly to the physician for services rendered. I understand I am financially responsible to Ankle & Foot Centers of Missouri, P.C. for any balances not covered by this authorization including deductibles, co-insurance, and co-pays. I understand that payment may be from federal and/or state funds. I further understand that I am responsible for payment should Medicare or Medicaid determine that the care I received is a non-covered service. I hereby authorize payments of my Medigap benefits to any/all doctors affiliated with Ankle and Foot Centers of Missouri, P.C. for all claims filed on my behalf. This authorization applies to all services until my representative or I revoke it.

Patient Signature/ Parent or Legal Guardian _____Date _____

continued on back →

Financial Policy

We work hard to provide the best service possible by filing your medical insurance information correctly the first time. In order to achieve this we need your assistance and understanding of your insurance's payment policy and procedures.

1. At check-in we **must** have your insurance card(s) and photo i.d. to copy for your chart. This allows us to follow up on any unpaid claims.

2. Co-pay(s) are due at time of check-in.

3. **We must ask that you reschedule your appointment, if you do not have your insurance card(s), referral, or your co-pay with you.**

4. Payment in full is due at time of check-in if you are paying cash for all services and/or your insurance policy is not a contracted carrier with our service.

5. A statement will be mailed on all balances due. Please review your statement for accuracy and report any errors to our billing office.

6. All returned checks will be assessed a $30.00 processing charge.

7. All outstanding balances past 30 days will be subject to receive interest of 1.5% regardless of payment until balance is zero. Accounts will be placed with a collection agency after 90 days if no payment activity. If you are on a payment plan and miss your monthly payment, the account will be placed with a collection agency. You agree to reimburse Ankle and Foot Centers of Missouri, P.C. the fees of the collection agency, which may be based on a percentage depending on the age of the amount owed (maximum of 50% of the debt) and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

We Do Accept Visa and MasterCard.

We must emphasize that your insurance is <u>your</u> policy. You need to be aware of your benefits and all restrictions. We deal with many insurance companies and it is impossible to know all the details for every individual's policy. Request a booklet from your insurance company explaining your policy, if you have not already received one. In order to get the best coverage for your medical care, you need to educate yourself about your plan.

Please feel free to ask any member of our office staff if you have any questions regarding any of the above information

Patient's or Legal Guardian Signature **Date**