

North Georgia Foot & Ankle Clinics, PC

132 Riverstone Terrace, Ste 101
Canton, GA 30114
678-880-0036 Phone
678-493-7051 Fax

PATIENT INFORMATION

Patient Name: _____ Phone: Home: _____ Cell: _____

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

Date of Birth: _____ Social Security #: _____ Sex: _____ Race : _____ Marital Status: _____

Employer: _____ Job Title: _____

Employer Address: _____ Work Phone: _____

Person to Contact in Case of Emergency: NAME: _____

Address: _____ Phone: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: _____ Address: _____

Relation to Patient: _____ Date of Birth: _____ Social Security # : _____

Employer: _____ Address: _____ Work Phone: _____

INSURANCE INFORMATION

Do you have Medicare? NO YES Do you have Medicaid? NO YES

Primary Insurance: _____ Secondary Insurance: _____

How did you hear about our office? _____

Family Physician: _____ Address: _____ Phone: _____

INSURANCE AUTHORIZATION & ASSIGNMENT

Referrals: Should your insurance company require a referral from your primary care physician before you can be seen, **it is your responsibility to obtain your referral prior to your appointment.** If you are seen without a referral, you must be prepared to pay for all services in full at the time they are rendered.

WE WILL GLADLY BILL YOUR INSURANCE IF WE ARE PROVIDERS.

I understand that SPENCO inserts (\$25) SURGICAL SHOES (\$10), and AMERIGEL (\$20) are my responsibility, and will not be billed to my insurance. 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. I hereby give my permission for the doctor to render the Podiatric examination and treatment. I understand that I am financially responsible to the Physician for all charges incurred by me or my dependents. I authorize the release of any medical information necessary to process any claim and request payment of insurance benefits due to be paid to the physician. I am financially responsible for any collection and/or attorney fees incurred if my account becomes delinquent. I am financially responsible for any service charges incurred on all returned checks.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND AGREE TO FINANCIAL RESPONSIBILITY AS DESCRIBED.

Responsible Party Signature

Date

