Gary C. Mashigian, DPM | **FOOTCARE, P.A.** | Sandra L. Gold, DPM

PATIENT INFORMATION

Name: ______________________________ Date: __________
Last First Middle

Street ______________________ City ______________________ State _____ Zip _____

Home Phone (_____) ______________ Work Phone (_____) ______________ Ext. _____ Sex M F

Social Security Number ______________________ Date of Birth ______________________

Referral Source: Family/Friend Insurance Phone Book Dr's Name ______________ Other ________

Employer Name ______________________ Occupation ______________________

POLICYHOLDER INFORMATION

Policyholder Name ______________________________ Sex M F
Last First Middle

Street ______________________ City ______________________ State _____ Zip _____
(If different than above)

Policyholder Home Phone (_____) ______________ Policyholder Work Phone (_____) ______________ Ext. _____

Policyholder SS# ______________________ Policyholder Date of Birth ______________________

Policyholder Employer Name ______________________ Relationship ______________
(If different than above)

EMERGENCY CONTACT INFORMATION

Contact Name ______________________ Address ______________________

Home Phone (_____) ______________ Work Phone (_____) ______________ Ext. _____

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of these expenses. We will wait 90 days for your insurance company to pay your claim and if they do not we will give you 30 days to pay the balance.

1. The patient is responsible to pay any deductible and copayments at the time services are rendered.
2. Any portion of a billed amount that is labeled "disallowed" or "over reasonable and customary" will become the patient's responsibility.
3. Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account immediately.
4. We will not file insurance for patients that do not live in Texas. We will provide you with a receipt so you may get reimbursement.

I understand all the above policies and agree to them. I authorize my insurance carriers to pay benefits directly to **Footcare, P.A.** on any unpaid services filed on my behalf by **Footcare, P.A.** I also understand that **Footcare, P.A.** is not ultimately responsible for collecting my insurance or negotiating settlements of claims. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information that is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. **FootCare, P.A.** is not bound by the restriction unless it is in agreement with the restriction.

Signature of Patient, Parent, or Agent: ______________________ **Date:** __________