

FINANCIAL INFORMATION AND AUTHORIZATION

PATIENT LAST NAME: _____ **FIRST:** _____ **MIDDLE:** _____

FINANCIAL TYPE (Check all those that apply)

Cash Group Insurance Medicare Auto Injury Workers Compensation

INSURANCE **We need to scan your insurance cards for our records**

Primary Insurance _____

Insured's Name _____ Employer _____

Secondary Insurance _____

Insured's Name _____ Employer _____

RESPONSIBLE PARTY (POLICYHOLDER OF INSURANCE)

Responsible Party or Policyholder _____ Date of Birth _____

Relationship to Patient _____ SS# _____

Home Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Employer Name _____

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co-payments or non-covered services as may be required by my insurance plan.

X _____

Signature of patient or person acting on patient's behalf

Date

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X _____

Signature of patient or person acting on patient's behalf

Date

AUTHORIZATION TO UPDATE MEDICATIONS

I authorize Advanced Regional Center for Ankle & Foot Care to access my list of medications via Surescripts and enter the information into my chart.

X _____

Signature of patient or person acting on patient's behalf

Date