The Agoura – Los Robles Podiatry Centers Welcome You to Our Office

Michael Zapf, Darren Payne, and Steven Benson
We Have Been Providing Foot and Ankle Care for Adults and Children Since 1982

PATIENT INFORMATION

Name (First, Middle Initial and Last)	Sex	Date of Birth	Age	Marital Status S M D W

Address	City	State	Zip	Home Phone ( )
E-mail Address				Race / Ethnicity

Drivers License #	Social Security #	Cell phone ( )
Can we send you confidential information to this e-mail address? ❐ Yes ❐ No		Which phone should we use to contact you? ❐ Home ❐ Cell
Would you like us to send appointment reminders this e-mail address? ❐ Yes ❐ No		Preferred method to contact you? ❐ Cell phone ❐ Home number ❐ Work Number ❐ e-mail

How did you hear about our office? Please be as specific as you can. ❐ Doctor (name) ❐ Friend/Family
❐ Yellow Pages (which book)__________ ❐ Newspaper (which)__________ ❐ Internet web search ❐ Magazine ❐ Insurance web site

Emergency Contact	Address	Phone ( )	Primary Care Physician:
Employer's Name and Address			Work Phone ( )

RESPONSIBLE PARTY

❐ Same as above. Name:		Relationship to patient
Address	City / State / Zip	Home phone ( )
Work phone ( )	Driver's license #	Social security #

INSURANCE INFORMATION

Primary insurance carrier	Secondary insurance carrier
Address	Address
City State Zip	City State Zip
Subscriber name Date of Birth Relationship to patient Employer	Subscriber name Date of Birth Relationship to patient Employer
Policy # Group #	Policy # Group #

By signing this I understand that payment for office visits or any procedures are expected when services are rendered unless other arrangements have been made in advance. I recognize that professional services are rendered and charged to me and not to my insurance company. I know and understand that **I am responsible for any non-covered services as well as co-payments and deductibles**. I understand that proof of eligibility, covered and non-covered services and various exclusions frequently cannot be determined until my carrier processes the claim. I know that billing insurance companies is a courtesy to me and that the podiatry office cannot accept the responsibility for collecting, negotiating or settling a disputed claim. I understand that filing of insurance claims does not guarantee payment by my carrier. **If my insurance company does not reimburse the office within 90 days of providing services, I agree to pay for the services myself** and, in turn, collect reimbursement from my insurance company. While the office tries to comply with the requirements of my insurance companies, it is my ultimate responsibility to be aware of the limits and qualifications of my own policy, including the requirements for second opinions, pre-authorizations, assistant surgeons and orthotic coverage. I agree to pay for any treatment I receive that my insurance company will not pay for. I understand that an interest charge of 1.5% per month will be charged on all outstanding accounts and that an administrative charge of $30 will be added to the account if it should ever be turned over to a collection agency. I understand that I will be notified by regular mail at least 30 days before my account is ever turned over to an agency. I agree to keep the office informed of address changes.

If arrangements are made for the office to bill an insurance company for services, I hereby assign all medical and surgical benefits to which I am entitled to the doctors. If my insurance company sends payment to me instead of the podiatry office, I will forward to the office any amounts due from my services. Furthermore, I hereby authorize this office to release any and all information concerning my examination or treatment to my insurance carrier to secure payment on my behalf. Finally, I authorize the doctors of The Agoura-Los Robles Podiatry Centers and my other treating doctors to share information in order to provide for my optimum health care. I understand that a copy of this policy will be given to me on request.

Finally, by my signature I acknowledge that I was provided a copy of the **Notice of HIPAA Privacy Practices** and that I have either read (or was given the opportunity to read) and understand the Notice. I also understand that, on request, a copy of the Privacy Practices will be given to me.

________________ Date

____________________________ Signature of Patient or Responsible Party