ADVANCED FOOT & ANKLE MEDICAL CENTERS

Advanced Foot & Ankle Medical Centers Welcomes You to Our Office

Name (First, Middle Initial, Last)	Gender	Date of Birth	Age

Street Address	City	State	Zip	Email Address

Home Telephone Number	Cell Number

In the event our office needs to get ahold of you to relay diagnostic, lab or imaging results, please share ☐I do not wish to have messages left which method we can leave confidential messages (if applicable): ☐Home Phone ☐Cell Phone ☐Email containing health information anywhere

Race	Ethnicity	Marital Status S M D W	Primary Care Physician

How did you hear about our office? ☐Dr. _____ ☐ Friend/Family _____

☐Yelp ☐ NextDoor ☐Insurance Website ☐Internet Search ☐Other _____

Employer Name	Occupation	Work Telephone Number

Emergency Contact: Name, Relation, Phone Number

I authorize my medical information to be shared with the following individual: ☐I do not authorize the release to anyone

Name	Relationship	Telephone Number

Responsible Party ☐Same as above Name Relationship Telephone Number

Address (if different than above)

Insurance Information Primary Insurance Carrier Secondary Insurance Carrier

Are you the subscriber? ☐Yes ☐No Subscriber name and DOB (if you are the dependent): _____

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 copayments and deductibles. I understand that proof of eligibility, coverage 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 this 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 the reimbursement from my insurance company. While the office tries to comply with the requirements of my insurance companies, it is ultimately my responsibility to be aware of the limits and qualifications of my own policy, including the requirements for second opinions, pre authorizations assistant surgeon 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. I authorize the physicians at the Agoura - Los Robles Podiatry centers to share information in order to provide my optimum care. Finally, by my signature I acknowledge that I have been advised of the HIPAA privacy rule which gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). **Please ask front office for a copy of our Privacy Practices if you wish**.

Date: _____ SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____