ADVANTAGE FOOT & ANKLE CENTER
PATIENT UPDATE

PATIENT INFORMATION

Patient's Last Name First	Middle	❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Nickname (Name I preferred to be called)	Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Spouse's Name
Street Address	Social Security #		Home Phone # ( )
City State Zip Code	E-Mail		Mobile Phone # ( )
Employer	Employer Address		Employer/Work Phone # ( )
Pharmacy Name & Phone #	Primary Care Physician (PCP)		Date PCP Last Seen

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Name of Person Responsible for Bill	Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other
Street Address	Social Security #		Home Phone # ( )
City State Zip Code	E-Mail		Mobile Phone # ( )
Employer	Employer Address		Employer/Work Phone # ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Social Security #

Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

ANY SIGNIFICANT MEDICAL CHANGES SINCE YOUR LAST VISIT?

ANY CHANGES TO MEDICATIONS SINCE YOUR LAST VISIT?

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Advantage Foot & Ankle Center all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Advantage Foot & Ankle Center may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

ADVANTAGE FOOT & ANKLE CENTER
FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

1. It is your responsibility to provide accurate insurance information and to present your insurance ID card and Photo ID (required by federal law) at the time of your visit. If you do not present a valid insurance card or photo ID, you will be rescheduled.

2. COPAYMENTS are due at the time of visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances and deductibles from patients can be considered a violation of the contract you have with your insurance company.

3. REFERRALS: If your plan requires a referral, it is your responsibility to obtain this from your PCP prior to being seen by our provider. If you do not have a valid referral, you will be rescheduled. (Referrals are done electronically, PCP must contact insurance company).

4. SELF PAY PATIENTS: Payment in full is due at the time of service.

5. As a courtesy, we will be happy to bill your primary and secondary insurance company on your behalf. It is up to each patient to know the rules and limitations of your policies.

6. You are responsible for any portion not covered by your insurance, such as deductible, co-insurance and/or copay. Please read your explanation of benefits to determine amounts owed.

7. If you believe your insurance company has made an error with the processing of your claim, it is up to the policyholder to contact the insurance company to dispute, file a grievance and/or appeal. Please read your explanation of benefits to determine amounts owed.

8. You are ultimately responsible for payment of charges for services you receive from our office.

9. PATIENT BALANCES: Payment is due for rendered services 30 days from receipt of your billing statement. Outstanding balances 60 days or older must be paid in full prior to any additional visit unless arrangements have been made with our billing department.

10. A $35.00 fee will be charged for any check returned for insufficient funds. Your insurance company does not cover this fee. If this happens, payment will only be accepted by cash or credit card.

11. Medical record requests must be received in writing. Fees for medical records are set in accordance with allowable amounts as defined by the State of Delaware. Fees must be received prior to record delivery.

12. Administrative Services: There is a $25.00 charge for **each** required Administrative Service, payable prior to service completion. This Administrative Service Fee covers specific forms such as FMLA and Short Term Disability and is not covered by insurance.

13. In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.

14. Our office accepts cash, checks (post-dated checks **are not** accepted), and credit cards (Visa, MasterCard, Discover and American Express).

I have read and understand the above Financial Policy for Advanced Foot & Ankle Center.

Signature of Patient, Parent or Legal Guardian _____

Date: ____/____/____