

# INSURANCE INFORMATION

Insurance Name: \_\_\_\_\_

Name of Person responsible for Account: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient? \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group# \_\_\_\_\_

Are you covered by a secondary insurance? (YES/NO) If yes please fill out following:

Insurance Name: \_\_\_\_\_

Name of person responsible for account: \_\_\_\_\_ DOB \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient? \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group# \_\_\_\_\_

# INSURANCE ASSIGNMENT AND RELEASE

I certify that I have Insurance with the following insurance(s):

\_\_\_\_\_  
(LIST ALL)

And I assign directly to Dr. Andrew Straley all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for the charges whether or paid by insurance and for all deductibles, coinsurance, and noncovered services. I authorize the use of my signature on all insurance submissions whether electronic or manual method. Dr. Andrew Straley may use my health care information and discloser such information to the above named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I request that payments of authorized Medicare benefits and/or Medigap benefits be made on my behalf to Dr. Andrew Straley for any services furnished to me. To the extent by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and /or Medicaid, my Medigap insurer, and their agents and information needed to determine these benefits or benefit for related services.

\_\_\_\_\_  
(PATIENT/GUARDIAN/PERSONAL REPRESENTATIVES) PRINTED NAME

\_\_\_\_\_  
RELATIONSHIP TO BENEFICIARY

\_\_\_\_\_  
(PATIENT/GUARDIAN/PERSONAL REPRESENTATIVE) SIGNATURE

\_\_\_\_\_  
DATE

# WELCOME TO AMERICAN FOOT AND ANKLE CENTER

705 MOBJACK PLACE, SUITE B,  
NNEWPORT NEWS, VA 23606  
PHONE: 757-873-2101 FAX: 757-873-2118

## PATIENT INFORMATION FORMS

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ Sex M/F Age: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Patient Status: Married/ Single/ divorced/ Widow/ Minor  
Cell Number \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Employer's Phone Number: \_\_\_\_\_  
Spouse Guardian Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_  
Nearest Friend Not Living With You: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Nearest Relative Not Living With You: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Day Time Phone Number: \_\_\_\_\_  
Emergency Contact Evening Phone Number/ Cell Phone: \_\_\_\_\_

### YOUR DOCTOR'S

	<u>NAME</u>	<u>PHONE NUMBER</u>	<u>CITY</u>	<u>MONTH/YEAR</u> <u>LAST SEEN</u>	<u>REFERRED</u> <u>YES/NO</u>
Primary care	_____ ( ) _____	_____	_____	_____/____	_____
Specialist:	_____ ( ) _____	_____	_____	_____/____	_____
Other Podiatrist:	_____ ( ) _____	_____	_____	_____/____	_____

Whom may we thank for referring you or how did you find out about our office?????

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I will be paying today by Cash: \_\_\_\_\_ Check: \_\_\_\_\_ Credit Card: \_\_\_\_\_

When you have been scheduled for an appointment in our office, we ask that you please contact our office 24 hours in advance, if for any reason you can not make your appointment.

I understand and agree that (regardless if my insurance) I am ultimately responsible for any professional services rendered because my insurance my not cover certain procedures. I certify this information is correct to the best of my knowledge I will notify thus office if any changes are made to the above information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_