"X" Location:

❑ Belleville ❑ O'Fallon ❑ Columbia ❑ Maryville ❑ Chester ❑ Sparta ❑ Staunton

PATIENT INFORMATION

Associated Foot Surgeons

20_____

PATIENT NAME:			DATE OF BIRTH:	Age:
SEX:	RACE:	ETHNICITY: ❑ Not Hispanic/Latino ❑ Hispanic/Latino	SSN:	
House ADDRESS:	City		State	Zip
PO BOX: ❑NA	HOME PHONE		CELL PHONE:	
Marital status: S M W D Sep	Language: ❑English ❑Other:		Driver's Lic# State:	
Email Address:				
Patient Employer:	Position:		Work Phone:	

(Guarantor Information) **PERSON RESPONSIBLE FOR THE BILL** ***(If other than above)***		
NAME: ❑ Self	❑ Spouse ❑ Parent ❑ Guardian ❑ Guarantor	
ADDRESS:	CITY	ZIP
SSN: ❑ Self	Driver's Lic# State:	
Email Address:		
Employer: ❑ Same as above	Home Phone	
Workplace Address:	Work Phone	

Attention: You are responsible for the bill if you provide incorrect insurance information at the time of the visit.

PRIMARY INSURANCE		SECONDARY INSURANCE	
INS. COMPANY NAME		INS. COMPANY NAME	
IDENTIFICATION #		IDENTIFICATION #	
GROUP #		GROUP #	
SPECIALTY COPAY:	CO INSURANCE:	SPECIALTY COPAY:	CO INSURANCE:
PRIMARY OWNER/SPONSOR'S NAME : ❑ Self		PRIMARY OWNER/SPONSOR'S NAME : ❑ Self	
OWNER/SPONSOR'S ADDRESS**If different than patient's. ❑ Same as patient's		OWNER/SPONSOR'S ADDRESS**If different than patient's. ❑ Same as patient's	
Sponsor's Date of Birth:		**Sponsor's Date of Birth:**	
RELATIONSHIP TO PATIENT: ❑ Self ❑ Spouse ❑Parent ❑Other:		RELATIONSHIP TO PATIENT: ❑ Self ❑ Spouse ❑Parent ❑Other:	

OVER

AUTHORIZATIONS: I understand that this authorization is voluntary and that I can refuse to sign this authorization. I do not have to assign a person to receive care. I may revoke this authorization at any time

RELEASE OF INFORMATION TO OTHERS: ❑ YES ❑ NO *(Must check one)*

I hereby authorize Associated Foot Surgeons, its representatives, physicians and staff to share any and all medical and financial information with the following individual(s): *(This may be revoked at any time.)*

(You do NOT need to list your primary or referring doctor)

1. Name:____Relationship:______________________________ ❑ Medical ❑ Financial

Home Phone: ___________________Work Phone: ___________________Cell Phone:___________________________

2. Name:____Relationship:______________________________ ❑ Medical ❑ Financial

Home Phone: _____________________Work Phone: ____________________Cell Phone:________________________

Emergency Contact Name	RELATIONSHIP TO YOU	Phone #
☐ ✓ if same as Release of Information		

MESSAGE AUTHORIZATION

- **I hereby authorize Associated Foot Surgeons, it's representatives, physicians and staff to leave message(s) related to my healthcare and appointment reminders using the following method:**

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email___________________________ ☐ Other: _______________

PRIMARY CARE PHYSICIAN

Primary Care Physician:		**Date of Last Appointment:**
City:	Phone:	Fax:

DO YOU SEE ANY OTHER SPECIALISTS? ☐ Cardiologist ☐Internal Medicine ☐Endocrinologist ☐Neurologist ☐Oncologist ☐Other ________________ Doctors Name:____________________________ Phone Number:______________________

ACKNOWLEDGEMENT AND CERTIFICATION OF INFORMATION

ASSIGNMENT OF BENEFITS TO PHYSICIAN/INSURANCE COMPANIES: ☐ YES ☐NO (If "no" is checked, you must be selfpay)
I hereby authorize payment directly to the physician for surgical and/or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company. Additionally, I authorize release of information for Insurance claim purposes.

RECEIPT OF "Notice of Privacy Practices":
We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the information provided, please ask to speak to our HIPAA Compliance Officer in person or by phone at our main phone number. (618-277-5700)

- **This is to acknowledge that you have received the Notice of our Privacy Practices.**
- **This also certifies that the insurance information you provided is current and accurate.**
- **You are personally responsible for any balances due if you provide wrong insurance information.**
- **If you are required by your insurance to have a referral and do not have one, you are responsible for any charges incurred.**
- **If you do not pay your bill within 30 days you will be charged an $8.00 rebilling fee each month. If not paid after 60 days, your account may be sent to collections. You will be responsible for any additional fees incurred.**

SIGNATURE OF UNDERSTANDING

I understand all of the information on this form and herby state that the information I have provided is correct to the best of my knowledge.

PATIENT'S SIGNATURE: ____

PARENT OR AUTHORIZED REPRESENTATIVE (If applicable) : ____

☐ Parent ☐ Legal Guardian ☐ Other: _________________________________ Date: ________________________