

2012

NORTH ATLANTA PODIATRY, d/b/a  
FOOT AND ANKLE CENTERS OF NORTHEAST GEORGIA  
www.footandanklecenters.com

Please complete both sides of form-all spaces-if not applicable, please indicate.

Adult/child (circle one) Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Male [ ] Female [ ]

Employer/School \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred Pharmacy (name & telephone#): \_\_\_\_\_

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PRIMARY INSURANCE \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Insured/Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Address (if different from patient) \_\_\_\_\_

Insured's Birth date \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Employer Telephone #: \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Insured /Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's Address (if different from patient) \_\_\_\_\_

Insured's Birth date \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Employer Telephone #: \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

**NOTIFY IN CASE OF EMERGENCY:** \_\_\_\_\_ Phone (wk) \_\_\_\_\_ (hm) \_\_\_\_\_

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**PAYMENT POLICY:** Our fees have been established to be competitive with other podiatrist in the surrounding medical community.

You, the patient, should understand clearly that verification of benefits for office and/or surgical procedures is not a guarantee of payment. The benefits quoted are based on the information obtained from the insurance company. I have read and understand the above disclaimer provided by my insurance company. Any patient co-pay will be payable at the time of service. We will bill your insurance company initially. However, please note that it is the patient's responsibility to see that the insurance company makes prompt payment. After the insurance company has processed the claim, the patient will receive a statement for any patient portion due. Payment of any balance is due upon receipt. If payment arrangements are not made within 30-days, the account will be turned over to collections.

Any incorrect insurance information must be corrected within 45 days or the bill will become patient responsibility and the claim will need to be filed by the participant.

Patient agrees to pay for each check returned for insufficient funds, or any other reason, \$45.00 per occurrence. Patients agree to pay all reasonable court and/or attorney's fees, (at least 15% of all amounts due, including interest) if an account is placed in collections. The parties agree that the only venue for any suit brought by either party with respect to the merchandise sold hereunder shall be in the State Court of Gwinnett County. Any financial matters may be discussed with our administrator, and written arrangements may be made in special circumstances.

I authorize the FOOT & ANKLE CENTER OF NE GEORGIA to release any information regarding my or my child's examination or treatment for the purpose of obtaining insurance compensation, precertification, or medical records.

I authorize payment of Medical benefits to FOOT & ANKLE CENTER OF NE GEORGIA when claim forms are filed upon my child's behalf or mine when hospitalized for treatment or having office procedures. I understand that I am responsible for the bill should my insurance company not pay within 30 days.

**PRIVACY PRACTICIES:** I acknowledge a receipt of a copy of the privacy practices.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Legal Guardian (if under 18)

Print Name \_\_\_\_\_