KENT FOOT AND ANKLE CENTER

WELCOME TO THE PRACTICE

Name ____ Date ________________________________

Address ____

City ____ State __________________ Zip ____________________

Home Phone __________________________________Work Phone_______________ Cell Phone ________________

E-mail Address ____

Social Security ____ Date of Birth _______________

Employer ____ Occupation________________________

Business Address ____________________________________ State ______________________ Zip _______________

Pharmacy ____ Location ______________________________________

Family Physician ____

RESPONSIBLE PARTY

Name of person responsible for this account ____

Relationship to Patient _____________________________________ Address _________________________________

Employer __________________________ Work Phone ________________________ Home Phone _________________

Social Security Number _______________________________________ Date of Birth ___________________________

I authorize the release of any information including the diagnosis and records of my treatment or examination rendered to me or my child during the period of such care to third payers and or health practitioners. I authorize and request my insurance company to pay directly to the Doctors' group insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual bill for service.' I agree to be responsible for the payment of all services on my behalf or my dependents.

X____ Date ______________________________

Signature of Patient or Parent, if Minor

MEDICARE AUTHORIZATION

I request payment of authorized Medicare benefits to be made either to me or on my behalf to Kent Foot and Ankle Center for any services furnished. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services. I understand that my signature request that payment be made and authorize release of any medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1200 form or elsewhere on the approved claim forms or electronically submitted claim, my signature authorizes releasing of the information to the insurer or agent shown. In Medicare assigned cases, the physician, or the supplier agrees to accept the charges determined of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services.

X ____ Date ______________________________

Signature of Beneficiary