PATIENT INFORMATION

Name _____ Email
Last First Middle Address_____

Address _____ Home Phone _____ Cell Phone_____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____Employer/School Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Ramos Foot and Ankle Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to my insurance Company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

A $25 fee will be assessed to patients that do not cancel their appointments in advance. Thank you.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

ACKNOWLEDGMENT OF RECEIPT OF NOTICES OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notices of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature