PATIENT REGISTRATION

PATIENT INFORMATION

Last Name	First	Middle	Title	Nickname (Preferred to be called)

Mailing Address	Birthdate (mm/dd/yyyy)	Sex ☐M ☐F

City	State	Zip code	Social Security #	Home Phone # ( )

Employer	Occupation	Email	Work Phone # ( )

Pharmacy Name & Phone #	Primary Care Physician (PCP)	Date PCP Last Seen	Mobile Phone # ( )

Emergency Contact Name	Relationship	Contacts Phone # ( )

PERSON RESPONSILE FOR BILL (IF DIFFERENT THAN ABOVE)

Name	Birth date (dd/mm/yyyy)	Sex ☐M ☐F	Relationship To Patient

Street Address	City	State	Zip code

Email	Home Phone # ( )	Mobile Phone # ( )

INSURANCE INFORMATION

Primary Insurance	Subscriber Name	Birth date (dd/mm/yyyy)

Insurance ID #	Group #	Effective Date	Co-Payment $

Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)

Insurance ID #	Group #	Effective Date	Co-Payment $

REFERRAL

How did you learn about us? (Please check all that apply) ☐ Internet ☐ Hospital/ER ☐ Insurance ☐ Dr. ______________________
☐ Friend/Family __________________________ ☐ Other ______________________________

PLEASE READ THE FOLLOWING: I hereby give my permission for Dr. Keeler and/or staff of Family Foot Clinic LLC to administer treatment as deemed necessary in the diagnosis and/or treatment of any podiatric medical condition.

OFFICE POLICIES: All non-covered cervices are due at the time of service. As a courtesy to me, my insurance claim will be processed provided all necessary information is presented. I understand that if my insurance company requires that my primary care physician refer me to Dr. Keeler and I have not obtained that referral, that any charges incurred will be, my responsibility. I also understand that I must notify Dr. Keeler of any need to pre-authorize treatment, and I accept responsibility for all charges for which pre-authorization is not obtained. **COPAYMENTS ARE DUE AT THE TIME OF SERVICE.** Statements are sent out monthly. My account will be assessed a rebilling charge of $20.00 per month for any balance over 90 days. Balances are not carried over 120 days. If my insurance company has not paid within that time frame, the balance over 120 days will my responsibility. If payment does not result, my account will be assigned to collections. I understand that if it becomes necessary to use outside attorney or collection efforts to bring my account to a paid status I will be charged an additional 33.3% of any unpaid balance at the time of referral for all costs of collection and/or attorney's fees. Also, I hereby authorize any insurance benefits to be payable directly to the physician. I am financially responsible for all non-covered charges. I also authorize the physician to release any medical information necessary in processing my insurance claim to my insurance company. A charge of $30.00 will be added to all returned checks. If you are unable to keep an appointment, we require you to give us 24-hour notice. There will be a $25.00 charge to all "no show" appointments or canceled appointments under 24 hours.

***Signature of Patient or Authorized Person:** ____ ***Date** ___________________