PATIENT LEGAL N. FirstLa		PRIMARY INSURANCE:
1 11 stLa	<u> </u>	Policy Holder Name
Address		Insured DOB
Address		Relationship to Insured
City	State 7:n	Address Same as Patient Y N
City		Insurance Name
Home Ph:		<del></del>
Cell Ph:		ID#
Work Ph:		Grp #
	Reach You During the Day d voice message for you? Y N	1
Date of Birth:		SECONDARY INSURANCE:
		Policy Holder Name
SSN:		Insured DOB
Marital Status:	<del></del>	Relationship to Insured
Race:	White Black Hispanic Other	Address Same as Patient Y N
Ethnicity:	Hispanic Non-Hispanic	Insurance Name
	English Spanish Other	
Email Address:		ID#
		Grp #
PRIMARY CARE PH	IYSICIAN:	1
Name:		
EMERGENCY CON	$\Gamma \Lambda C T \cdot$	
Name:		
Ph:	it:	
Relationship to patien		
How did you hear abo	out the practice? (circle one)	
•	out the practice? (circle one) Friend/Family	Doctor Referral (who?)
Internet/Google	Friend/Family	Doctor Referral (who?)
Internet/Google	Friend/Family	Doctor Referral (who?) Other
Internet/Google Insurance Company	Friend/Family	
Internet/Google Insurance Company  OFFICE POLICIES:	Friend/FamilyFacebook	Other
Internet/Google Insurance Company  OFFICE POLICIES: Protected Health Infor	Friend/FamilyFacebookFacebook	Other
Internet/Google	Friend/FamilyFacebookFacebook	Otherrsonal information regarding my care, treatment or Financial
Internet/Google	Friend/FamilyFacebookFacebook	Otherrsonal information regarding my care, treatment or Financial
Internet/Google	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss pe lowing people: in in effect until revoked in writing. I acknowledge and the second sec	Other
Internet/Google	Friend/FamilyFacebookFacebookFacebook	Otherrsonal information regarding my care, treatment or Financial
Internet/Google	Friend/FamilyFacebookFacebookFacebook	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of
Internet/Google	Friend/FamilyFacebookFacebookFacebook	Otherrsonal information regarding my care, treatment or Financial
Internet/Google_ Insurance Company  OFFICE POLICIES: Protected Health Infor Nashville Family Foot Ca obligations with the foll Authorization will rema Privacy Practices and th Assignment and Releas I, the undersigned, certif Nashville Family Foot Ca	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss pe lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  se fy that I or my dependent have insurance where, PLLC all benefits, if any, otherwise pay	orsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to
Internet/Google_ Insurance Company  OFFICE POLICIES: Protected Health Infor Nashville Family Foot Ca obligations with the foll Authorization will rema Privacy Practices and th Assignment and Releas I, the undersigned, certif Nashville Family Foot Ca	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss pe lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  se fy that I or my dependent have insurance where, PLLC all benefits, if any, otherwise pay	orsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of
Internet/Google_ Insurance Company_  OFFICE POLICIES: Protected Health Infor Nashville Family Foot Ca obligations with the foll Authorization will rema Privacy Practices and th Assignment and Releas I, the undersigned, certif Nashville Family Foot Ca this signature on all insu Financial Policy I understand that all acc	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknown at I have read and understand the Notice.  se fy that I or my dependent have insurance where, PLLC all benefits, if any, otherwise pay arance submissions. I also consent to treat ount balances not paid within 30 days of i	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of tment for my condition as directed by my physician.
Internet/Google_ Insurance Company  OFFICE POLICIES: Protected Health Infor Nashville Family Foot Ca obligations with the foll Authorization will rema Privacy Practices and th Assignment and Releas I, the undersigned, certif Nashville Family Foot Ca this signature on all insu Financial Policy I understand that all acc collected. I also underst	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  see fy that I or my dependent have insurance where, PLLC all benefits, if any, otherwise pay arrance submissions. I also consent to treat ount balances not paid within 30 days of it and that I am responsible for all collection	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of timent for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until to or legal fees associated with the collection of my account to
Internet/Google	Friend/FamilyFacebook	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of tment for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until nor legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will
Internet/Google	Friend/Family Facebook  Fa	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of tment for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until or legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will ble by me.
Internet/Google_ Insurance Company  OFFICE POLICIES: Protected Health Infor Nashville Family Foot Ca obligations with the foll Authorization will rema Privacy Practices and th Assignment and Release I, the undersigned, certif Nashville Family Foot Ca this signature on all insu Financial Policy I understand that all acc collected. I also underst include court cost, attor be in addition to the bala All returned checks will	Friend/Family Facebook  Fa	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of tment for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until nor legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will ble by me.  patients. If on the second deposit the check is returned the
Internet/Google_ Insurance Company  OFFICE POLICIES: Protected Health Infor Nashville Family Foot Ca obligations with the foll Authorization will rema Privacy Practices and th Assignment and Releas I, the undersigned, certif Nashville Family Foot Ca this signature on all insu Financial Policy I understand that all acc collected. I also underst include court cost, attor be in addition to the bala All returned checks will amount of the check will	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  Se fy that I or my dependent have insurance and the PLLC all benefits, if any, otherwise pay arance submissions. I also consent to treat ount balances not paid within 30 days of it and that I am responsible for all collection ney cost, or cost of a collection company of ance on my account and are due and payal be re-deposited once as a courtesy to our I be added back to the patient's account and	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of timent for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until a or legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will be by me.  patients. If on the second deposit the check is returned the and a non-sufficient funds fee of \$25.00 will be charged to the
Internet/Google_ Insurance Company	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  se fry that I or my dependent have insurance of the place of the payment of the	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of tment for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until nor legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will ble by me.  patients. If on the second deposit the check is returned the
Internet/Google_ Insurance Company	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  se fry that I or my dependent have insurance of the place of the payment of the	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of timent for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until a or legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will be by me.  patients. If on the second deposit the check is returned the and a non-sufficient funds fee of \$25.00 will be charged to the
Internet/Google_ Insurance Company	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  se fy that I or my dependent have insurance where, PLLC all benefits, if any, otherwise pay arance submissions. I also consent to treat ount balances not paid within 30 days of it and that I am responsible for all collection ney cost, or cost of a collection company counce on my account and are due and payal be re-deposited once as a courtesy to our I be added back to the patient's account are duding NSF fee must be paid in full by eith econd occurrence.	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of timent for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until a or legal fees associated with the collection of my account to contracted by Nashville Family Foot Care, PLLC. These fees will be by me.  patients. If on the second deposit the check is returned the and a non-sufficient funds fee of \$25.00 will be charged to the er cash or money order within 10 days of receipt of the
Internet/Google_ Insurance Company	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  see fy that I or my dependent have insurance was are, PLLC all benefits, if any, otherwise pay arance submissions. I also consent to treat ount balances not paid within 30 days of it and that I am responsible for all collection ney cost, or cost of a collection company counce on my account and are due and payal be re-deposited once as a courtesy to our I be added back to the patient's account are duding NSF fee must be paid in full by eith econd occurrence.  Insurance company requires that prior automic process.	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of tment for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until a or legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will be by me.  patients. If on the second deposit the check is returned the ad a non-sufficient funds fee of \$25.00 will be charged to the er cash or money order within 10 days of receipt of the
Internet/Google_ Insurance Company	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  se fy that I or my dependent have insurance where, PLLC all benefits, if any, otherwise pay arance submissions. I also consent to treat ount balances not paid within 30 days of it and that I am responsible for all collection ney cost, or cost of a collection company counce on my account and are due and payal be re-deposited once as a courtesy to our I be added back to the patient's account are duding NSF fee must be paid in full by eith econd occurrence.	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of tment for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until a or legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will be by me.  patients. If on the second deposit the check is returned the ad a non-sufficient funds fee of \$25.00 will be charged to the er cash or money order within 10 days of receipt of the
Internet/Google_ Insurance Company	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  see fy that I or my dependent have insurance was are, PLLC all benefits, if any, otherwise pay arance submissions. I also consent to treat ount balances not paid within 30 days of it and that I am responsible for all collection ney cost, or cost of a collection company counce on my account and are due and payal be re-deposited once as a courtesy to our I be added back to the patient's account are duding NSF fee must be paid in full by eith econd occurrence.  Insurance company requires that prior automic process.	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of tment for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until a or legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will be by me.  patients. If on the second deposit the check is returned the ad a non-sufficient funds fee of \$25.00 will be charged to the er cash or money order within 10 days of receipt of the
Internet/Google_ Insurance Company	Friend/Family Facebook  mation and Notice of Privacy Practices are, PLLC has my permission to discuss per lowing people: in in effect until revoked in writing. I acknow at I have read and understand the Notice.  se fy that I or my dependent have insurance where, PLLC all benefits, if any, otherwise pay arance submissions. I also consent to treat ount balances not paid within 30 days of it and that I am responsible for all collection new cost, or cost of a collection company company company company control and are due and payal be re-deposited once as a courtesy to our I be added back to the patient's account are luding NSF fee must be paid in full by eith econd occurrence.  Insurance company requires that prior auting the referral or prior authorization is my	rsonal information regarding my care, treatment or Financial nowledge that I was provided with a copy of the Notice of with the previously stated insurance carrier and assign to vable to me for services rendered. I further authorize the use of timent for my condition as directed by my physician.  nitial billing will incur a billing charge of 1.5% per month until a or legal fees associated with the collection of my account to ontracted by Nashville Family Foot Care, PLLC. These fees will be by me.  patients. If on the second deposit the check is returned the ad a non-sufficient funds fee of \$25.00 will be charged to the er cash or money order within 10 days of receipt of the