PATIENT LEGAL NAME & ADDRESS:
First ____________Last_______________

Address______________________________

City_______________ State_____ Zip
Home Ph: ____________________
Cell Ph: ______________________
Work Ph: _____________________
Circle Best Number to Reach You During the Day
May we leave a detailed voice message for you? Y N
Date of Birth: _________________
SSN: ____________________
Marital Status: __________________

Race: White Black Hispanic Other
Ethnicity: Hispanic Non-Hispanic
Language: English Spanish Other
Email Address: ___________________________

PRIMARY CARE PHYSICIAN:
Name:

EMERGENCY CONTACT:
Name: ______________________
Ph: ________________________
Relationship to patient: _______________________

PRIMARY INSURANCE:
Policy Holder Name __________________________
Insured DOB ___________
Relationship to Insured _____________________
Address Same as Patient Y N
Insurance Name___________________________

ID # __________________________
Grp # __________________________

SECONDARY INSURANCE:
Policy Holder Name__________________________
Insured DOB ____________
Relationship to Insured _____________________
Address Same as Patient Y N
Insurance Name

ID # _________________________
Grp # ________________________

How did you hear about the practice? (circle one)

Internet/Google_______________ Friend/Family_______________ Doctor Referral (who?)________________________
Insurance Company____________ Facebook__________________ Other______________________________________

OFFICE POLICIES:

Protected Health Information and Notice of Privacy Practices

Nashville Family Foot Care, PLLC has my permission to discuss personal information regarding my care, treatment or Financial obligations with **the following people:** ____
Authorization will remain in effect until revoked in writing. I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read and understand the Notice.

Assignment and Release

I, the undersigned, certify that I or my dependent have insurance with the previously stated insurance carrier and assign to Nashville Family Foot Care, PLLC all benefits, if any, otherwise payable to me for services rendered. I further authorize the use of this signature on all insurance submissions. I also consent to treatment for my condition as directed by my physician.

Financial Policy

I understand that all account balances not paid within 30 days of initial billing will incur a billing charge of 1.5% per month until collected. I also understand that I am responsible for all collection or legal fees associated with the collection of my account to include court cost, attorney cost, or cost of a collection company contracted by Nashville Family Foot Care, PLLC. These fees will be in addition to the balance on my account and are due and payable by me.
All returned checks will be re-deposited once as a courtesy to our patients. If on the second deposit the check is returned the amount of the check will be added back to the patient's account and a non-sufficient funds fee of $25.00 will be charged to the patient. The balance including NSF fee must be paid in full by either cash or money order within 10 days of receipt of the returned check on the second occurrence.

Referral Policy

I understand that if my insurance company requires that prior authorization or a referral is required in order for benefits to be considered that obtaining the referral or prior authorization is my sole responsibility.

___________________________ ___________
Signature of Patient/Legal Guardian Date