



NAME: _____

PERSONAL INFORMATION NEEDED TO FILE WITH YOUR INSURANCE COMPANY:

Birth Date _____ Age: _____ SS# _____

Address: _____ City/State _____

Zip: _____ Email address: _____

Phone _____ Cell Phone _____ Pager _____

If student, name of College/School _____ Full time ___ Part time ___

Patient's Employer _____ Phone _____

Business address _____ City/State _____ Zip _____

Spouse's name _____ Birth Date: _____ SS# _____

Spouse's employer _____ Work phone _____

Business address _____ City/State _____ Zip _____

Person and Phone to contact in an emergency _____

Person responsible for account:

Name _____ Relationship _____

Birth date _____ SS# _____ Employer _____

Work Address _____ City/State _____ Zip _____

Work Phone _____ Home phone _____ Cell phone _____

Home address _____

Insurance Information: Primary Insurance Secondary Insurance

Name of Company: _____ _____

Policy Holder's Name: _____ _____

Please read and sign the following authorization and assignment information:

I hereby authorize Dr. Brad Beasley, Dr. Shelley Hogue and the employees of Restoration Foot & Ankle, PLLC to furnish information to insurance carriers concerning my illnesses and I hereby assign to the doctor(s) all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance or Medicare. I hereby give permission to the above mentioned doctors to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot or ankle condition. I also authorize the use of clinical photography to document my condition and understand that this may be used in lectures, scientific papers, and clinical training. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services rendered unless arrangements are made in advance. I AUTHORIZE THE USE OF MY SIGNATURE ON THIS FORM FOR ALL MY INSURANCE SUBMISSIONS. TO MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES MADE BY THE ABOVE NAMED PATIENT. I UNDERSTAND THAT A MONTHLY SERVICE CHARGE OF 1½ % (18% annually) MAY BE ADDED TO ANY BALANCE NOT PAID WITHIN 30 DAYS. My signature below also confirms that a copy of this office's privacy policy has been made available to me.

Patient's Signature _____ Date _____

(If patient is under 18, this must be signed by a parent or guardian)