Restoration FOOT & ANKLE

NAME:_____

Birth Date_____ Age: _____ SS# _____ Email: _____

Address:_____ City/State _____ Zip: _____

Phone_____ Mobile_____ Other phone: _____

Patient's Employer_____Phone_____

Business address _____ City/State_____ Zip_____

Spouse's name _____Birth Date:_____ SS#_____

Pharmacy _____ Emergency Contact _____

Person responsible for account: (___ check here if same as above)

Name _____Relationship_____

Birth date_____SS#_____Employer_____

Work Phone_____ Home phone _____ Mobile _____

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. Beasley, Dr. 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. I understand that an unannounced no show or same day cancellation will result in a $35 fee should I choose to be reappointed. I understand that two unannounced missed appointments or same day cancellations will result in dismissal from this practice. I AUTHORIZE THE USE OF MY SIGNATURE ON THIS FORM FOR ALL MY INSURANCE SUBMISSIONS. TO MY KNOWLEDGE THE ENTERED HEALTH AND PERSONAL INFORMATION IS CORRECT. My signature below also confirms that a copy of our privacy and financial policy has been made available to me and any questions I have regarding that policy have been answered.

Patient's Signature _____ Date _____
(If patient is under 18, this must be signed by a parent or guardian)

I give permission to Restoration Foot & Ankle, PLLC to discuss my medical and/or billing information with the following persons either by oral or written communication (i.e. certain family members, friends, etc):

1. _____ 3. _____
2. _____ 4. _____

Patient's Signature _____ Date _____
(If patient is under 18, this must be signed by a parent or guardian)