PATIENT'S NAME: _____

TODAY'S DATE: _____

DATE OF BIRTH: _____

BILLING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SOCIAL SECURITY #: _____

HOME #: _____ **CELL #:** _____

WORK #: _____

PRIMARY DR: _____ **REFERRAL SOURCE:** _____

PHARMACY: _____ **PHARMACY LOCATION:** _____

EMAIL ADDRESS: _____

ASSIGNMENT AND RELEASE

I, THE UNDER SIGNER, CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO SOUTHERNMOST FOOT AND ANKLE ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR COSTS NOT COVERED BY THIRD PARTY PAYERS. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION, INCLUDING INFORMATION WHICH MAY BE CONSIDERED AS A COMMUNICABLE OR VENEREAL DISEASE, INCLUDING HEPATITIS, SYPHILIS, GONORRHEA, HIV, AND AIDS, NECESSARY TO SECURE THE PAYMENT OF BENEFITS TO ANY RESPONSIBLE PARTY. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS & CERTIFY THAT THE INFORMATION PROVIDED HERE IS TRUE AND CORRECT.

_____

PATIENT / GUARANTOR SIGNATURE

CONSENT TO TREAT

I REQUEST AND AUTHORIZE THE PHYSICIAN AND HIS STAFF TO PROVIDE ME WITH TREATMENT TO PERFORM ANY PROCEDURES NOW CONTEMPLATED OR SUCH ADDITIONAL PROCEDURES AS MY DOCTOR MAY DEEM REASONABLE AND NECESSARY.

I AUTHORIZE THE SOCIAL SECURITY ADMINISTRATION TO DISCLOSE INFORMATION REGARDING MY MEDICARE COVERAGE, INCLUDING BUT NOT LIMITED TO, VERIFICATION OF MY MEDICARE NUMBER, EFFECTIVE DATES AND TYPE OF COVERAGE

THE UNDERSIGNED CERTIFIES THE HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THAT PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. IT IS FURTHER UNDERSTOOD THAT THIS RELEASE REMAINS IN EFFECT FOR ONE (1) YEAR UNLESS OTHERWISE REVOKED.

_____

PATIENT / GUARANTOR SIGNATURE

THIRD PARTY LIABIILTY

I, _____ , ACKNOWLEDGE THAT THE PURPOSE FOR MY TREATMENT TODAY WITH DR. MAKIMAA / DEROUOIN **IS NOT AS A RESULT OF A WORK, AUTO, OR ANOTHER THIRD PARTY INJURY**. SOUTHERNMOST FOOT AND ANKLE SPECIALIST' STAFF HAVE EXPLAINED THAT IF THIS IS THE REASON FOR TODAY'S VISIT, MY PERSONAL INSURANCE COMPANY WILL REFUSE PAYMENT AND I WILL BE RESPONSIBLE FOR THE ENTIRE BALANCE. SOUTHERNMOST FOOT AND ANKLE SPECIALISTS WILL NOT PURSUE PAYMENT FOR ANY THIRD PARTY. SOUTHERNMOST FOOT AND ANKLE SPECIALISTS ARE HAPPY TO VERIFY AND BILL MY PERSONAL INSURANCE FOR ANY OTHER (NON-WORK, NON-AUTO, AND NON-LEGAL ISSUE) CONDITION WITH WHICH I PRESENT.

AGREED, AND ACCEPTED BY:

_____

PATIENT / GUARANTOR SIGNATURE

NOTICE OF PRIVACY PRACTICES

I, _____, HAVE READ A COPY OF SOUTHERNMOST FOOT AND ANKLE SPECIALIST'S NOTICE OF PRIVACY PRACTICES.

_____

PATIENT / GUARANTOR SIGNATURE