

**1. INSURANCE – Please Present Your Insurance Forms, Cards, and ID to the Receptionist  
You only need to fill the top part of this form out if the patient is not the cardholder!**

Primary Insurance				Secondary Insurance			
Patient: First	Middle	Last		Patient: First	Middle	Last	
_____ Primary Carrier Name:				_____ Secondary Carrier Name:			
_____ Cardholder's Name:				_____ Cardholder's Name:			
_____ Cardholder's Birth Date: / /				_____ Cardholder's Birth Date: / /			
_____ Member policy ID or SS# of Cardholder:				_____ Member policy ID or SS# of Cardholder:			
_____ Patient Relationship to Cardholder (circle one)				_____ Patient Relationship to Insured (circle one)			
Self	Spouse	Child	Other	Self	Spouse	Child	Other

**INSURANCE AGREEMENT: DIRECT ASSIGNMENT & INFORMATION RELEASE**

I/ we hereby name Fox Valley Foot Specialists, LTD as my/our assignee. I/We instruct my/our health care benefits plan administrator, ie; insurance company, HMO, employer or government benefits provider, hereafter referred to as the PLAN, to pay Fox Valley Foot Specialists, LTD directly for all professional and medical services provided by Fox Valley Foot Specialists, LTD. Through the means of electronic funds transfer(s) (EFT) or by checks made payable to and mailed to Fox Valley Foot Specialists, LTD. If my current policy prohibits direct payment to doctors, then I/we hereby instruct and direct the PLAN to make out all checks payable to me/us and mail the payments to me/us in care of Fox Valley Foot Specialist, LTD.

**FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT**

The Responsible Parties whose signatures appear below agree as follows:

- The Doctor(s), Associate Doctor(s), and staff of Fox Valley Foot Specialists, LTD, are authorized to medically treat the patient named on this form and to exchange past, present and future medical information with the patient's other medical care givers for the purpose of enhancing and promoting the continuity of care for the patient.
- The Responsible Parties agree to pay for all fees and charges for supplies, services and treatments that are incurred by the patient per the terms of this agreement and authorize the Fox Valley Foot Specialists, LTD or agents thereof to make credit investigations, including employment verifications. All charges shown of billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until Fox Valley Foot Specialists, LTD receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.
- Not all services and/ or fees are covered by the benefits plan of the Responsible Parties' health care insurance (i.e. insurance company, HMO, employer or government benefits provider) hereafter referred to as the PLAN. Therefore, the Responsible Parties agree to pay for all deductibles, co-payment, non-covered services, and any portion of covered services not paid in full by the PLAN and understands that such payments are due at the time of service or immediately upon presentation of the bill.

**Agreed to and accepted by the Responsible Parties:**

For the purpose of obtaining payment for services rendered, I/we give Fox Valley Foot Specialist, LTD, authorization to release and/or exchange medical, billing and collection information.

X \_\_\_\_\_ DATE: \_\_\_\_\_