INSURANCE INFORMATION

PATIENT NAME: _____

PRIMARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____/_____/_____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____/_____/_____

RELATIONSHIP TO PATIENT: _____

TERTIARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____/_____/_____

RELATIONSHIP TO PATIENT: _____

INSURANCE ASSIGNMENT AND RELEASE:

I certify that I have active coverage with the insurance listed above and assign directly to The Foot and Ankle Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the release of my health care information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

SIGNATURE OF PERSON RESPONSIBLE **DATE**