

PURVIS FOOT & ANKLE CENTER – PF&AC

Dr. Carl G. Purvis & Dr. Peter Moyer, Medical & Surgical Foot & Ankle Specialists

We would like to welcome you to our office. Thank you for choosing us for your podiatric services.

Name _____ Age _____ Birthdate _____ Race _____
First Middle Last

Mailing Address _____ City _____ State _____ Zip _____

Street Address _____ City _____ State _____ Zip _____

County _____ Driver License #/State _____ Sex: M F Marital Status: S M D W

Home Phone _____ Cell Phone _____ E- Mail _____

Preferred Method of Communication _____ Ht. _____ Wt. _____

How did you find out about us: Family/Friend Internet Doctor Phone Other _____

Social Security Number (required in full to be seen) _____

Patient's Employer _____ Work # _____

Occupation _____ City / State _____

Spouse's Name _____ DOB _____ SS # _____

Spouse's Employer _____ Work # _____

Nearest Relative Not Living With You _____ Relationship _____ Phone # _____

Were you referred for consultation? _____ By Whom? _____

Who is your family physician? (First and Last Name) _____

Pharmacy/Location _____

INSURANCE INFORMATION

Company # 1 _____ Company # 2 _____ Company #3 _____

Please give your insurance card(s) to receptionist for photo copying. (Without current insurance cards you will be considered a cash account.)

Person responsible for payment: _____

PLEASE READ CAREFULLY

I give permission to PF&AC to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. I request that my insurance company pay benefits directly to PF&AC. I agree that I am responsible for any amount not covered by my insurance. I agree that it is my responsibility to obtain any referral necessary from my insurance company or Primary Care Physician as required to process my insurance claims.

In the event that I need hospitalization, surgery and/or durable medical equipment, I agree that it is my responsibility to inform the Doctor of my insurance company requirements regarding precertification, second opinions and other requirements.

I understand that monthly finance charges will be added to overdue accounts. I understand that even though Purvis Foot & Ankle Center files with my insurance company, if for some reason they do not pay, I accept full responsibility for payment.

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL INFORMATION

I authorize Purvis Foot & Ankle Center to release and/or receive medical information to or from my insurance company or any facility that requires information to provide payment or outside care.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient's Signature _____ **Date** _____

Responsible Party's Signature _____ Relationship _____