

## PATIENT INFORMATION

NAME \_\_\_\_\_ HOME PH. \_\_\_\_\_  
FIRST M.I. LAST  
ADDRESS \_\_\_\_\_ WORK PH. \_\_\_\_\_ EXT. \_\_\_\_\_  
STREET CITY ZIP  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_  
STREET CITY ZIP  
AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
SEX  M  F MARITAL STATUS  M  S  W  D DRIVER'S LICENSE # \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL: (circle) SELF SPOUSE PARENT CHILD OTHER: \_\_\_\_\_  
NAME \_\_\_\_\_ HOME PH. \_\_\_\_\_  
FIRST M.I. LAST  
ADDRESS \_\_\_\_\_ WORK PH. \_\_\_\_\_ EXT. \_\_\_\_\_  
STREET CITY ZIP  
SEX  M  F AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
NAME ADDRESS

IF PATIENT IS DEPENDENT COMPLETE THIS SECTION AND CIRCLE RELATIONSHIP TO RESPONSIBLE PARTY: SPOUSE CHILD PARENT OTHER  
DEPENDENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_ SEX  M  F

FIRST INSURANCE NAME \_\_\_\_\_  
INSURED PERSON'S NAME \_\_\_\_\_ INSURANCE I.D.# \_\_\_\_\_ GROUP # \_\_\_\_\_  
SECOND INSURANCE NAME \_\_\_\_\_  
INSURED PERSON'S NAME \_\_\_\_\_ INSURANCE I.D.# \_\_\_\_\_ GROUP # \_\_\_\_\_  
THIRD INSURANCE NAME \_\_\_\_\_

PATIENT'S FAMILY DR. \_\_\_\_\_ DO YOU HAVE A "LIVING WILL"?  YES  NO  
HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

**I WILL PAY FOR SERVICES RENDERED AT THE TIME THEY ARE RENDERED UNLESS OTHER PRIOR ARRANGEMENTS HAVE BEEN MADE.**

To my insurance companies and/or the social security administration, or their representative; I authorize and request the release of any information about me needed to process claims for services rendered to me by the Orlando Foot & Ankle Clinic and I authorize and request payment to be made to the Orlando Foot & Ankle Clinic on my behalf for services provided to me for which I do not pay for in full at the time services are rendered. I authorize the Orlando Foot & Ankle Clinic to submit claims for me on my behalf. I permit a copy of this authorization to be used in place of the original. My signature below will act as my authorization for the above as long as I am provided services by the Orlando Foot & Ankle Clinic. I authorize Orlando Foot & Ankle Clinic physicians to consult with other physicians concerning my case as deemed necessary by them. I authorized the photographic and audio recording of my feet and or legs for the purpose of documentation as deemed necessary by Orlando Foot & Ankle Clinic. I understand that my account will incur a 1.5% per month service charge on balances not paid by my insurance company. I agree to pay all balances due, plus a 1.5% service charge on any unpaid balances plus collection costs.

DATE \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR  
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Claim Group: \_\_\_\_\_

SS # / ID #: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to ORLANDO FOOT & ANKLE CLINIC, or if my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

ORLANDO FOOT & ANKLE CLINIC  
P.O. BOX 140233  
ORLANDO, FL 32814-0233

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

Payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges that are applied to a deductible or copay requirement of my policy, or for any services provided that are not a covered benefit under my policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than policyholder.

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM! THIS WILL BETTER ENABLE US TO SERVE YOU.**