☐ **CHANGE OF ADDRESS:** **Received** NP

Old Zip Code _____
New Zip Code _____

2025

TFFA PATIENT INFORMATION FORM

(Please Print)

Patient's Name _____ **DOB** _____

Address _____ **Apt/Sp #** _____ **City, State** _____ **Zip** _____

Home Phone _____ **SS#** _____ **Sex** _____ **Marital Status** _____

Contact/CG _____ **Phone** _____ **Place of Service** Home

ACP/Medical POA _____ **Phone** _____

Guar./Financial Responsibility self **Address** _____

Phone _____ **Email Address** _____ **Referred by** _____

PCP _____ **Phone** _____ **Fax** _____

PRIMARY INSURANCE ☐ **HOSPICE:** _____

COMPANY _____ **POLICY# (NEW)**_____ **(OLD)** _____

Phone _____ **Insured Name** _____ **Insured Employer** _____

Insured DOB _____ **Insured Age** _____ **Insured Home Phone** _____ **SS#** _____

Relationship to Patient Self **VERIFIED:** ☑ **YES** ☐ **NO** _____ **DATE:** _____

_____ _____ _____ _____ _____

SECONDARY INSURANCE

COMPANY _____ **POLICY #** _____

GROUP# _____ **AUTHORIZATION #** _____

Phone _____ **Insured Name** _____ **Insured Employer** _____

Insured DOB _____ **Insured Age**_____ **Insured Home Phone** _____ **SS#** _____

Relationship to Patient Self

Financial Hardship Statement: I am Verified **Hospice-QMB** or **MC-QMB** and, due to financial hardship am unable to pay a copay or any balance due over **$**_____ at this time. **Signature:** _____ **Date:** _____

Financial Agreement and Authorization for Treatment:

I authorize treatment of the above and agree to pay all fees and charges for each treatment. I do understand the financial responsibility for payment is my responsibility regardless of insurance, **including annual Medicare deductibles and copays**. I also hereby assign and authorize any payment to be made directly to **Toe-Tal Family Foot Care Associates.** I authorize the **RELEASE OF PERSONAL MEDICAL RECORDS** of treatment from my primary care physician, from my insurance company, and attorneys in connection with the above assignments. I understand that payment for services are due upon treatment. **You are entitled to a copy of this agreement at the time you sign.**

We reserve the right to charge for appointments cancelled or broken without 24-hour notice, as well as a "no show" fee of $75.00 when the doctors arrive and patient is not home after confirming appointment. We also reserve the right to charge for any surgery cancelled or broken without 72-hour notice.

Patient's Signature _____ **Date** _____

I currently have a copy of my:

NEW MEDICARE CARD: ☐ **YES** ☐ **NO** ____ **initials**

OLD MEDICARE CARD: ☐ **YES** ☐ **NO** ____ **initials**

SECONDARY INSURANCE CARD: ☐ **YES** ☐ **NO**