☐ CHANGE OF ADDRESS:

Old Zip Code _____

New Zip Code _____

Received _____NP_____

2022

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 _____

ACP/Medical POA _____ Phone _____

Guar./Financial Responsibility _____ 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 _____ 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 _____

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 $40.00 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

(rev.: 6/4/2019)