

INSURANCE

POLICY HOLDER'S NAME

DATE OF BIRTH

MONTH	DAY	YEAR	SEX (M/F)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

NAME OF PRIMARY INSURANCE COMPANY

SOCIAL SECURITY NUMBER

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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INSURANCE ID#

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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GROUP #

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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INSURANCE BILLING ADDRESS

PCP NAME

PCP PHONE #

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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CO-PAY AMOUNT

REFERRAL #:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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TYPE OF POLICY INDIVIDUAL DEPENDENT FAMILY

SELF-PAY

CHARGE

100%	80%	60%	50%	40%	0%
A	B	C	D	F	E

COURTESY SERVICES

STAFF	STUDENT	GUEST OF	RELATIONSHIP	OTHER	SPECIFY WHO
A	B	C		D	

BILL TO

IF OTHER THAN PATIENT, ENTER THE REQUIRED INFORMATION BELOW

LAST NAME

FIRST NAME

M.I.

HOUSE NUMBER AND STREET

APT. NUMBER

P.O. BOX NUMBER

CITY

STATE

<input type="text"/>	<input type="text"/>
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ZIP CODE

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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RELATIONSHIP TO PATIENT

ORIGINAL SIGNATURE

- ENGLISH: 1.) I _____, AGREE TO BE FULLY RESPONSIBLE FOR ALL BILLS OF ALL THE SERVICES GIVEN TO ME AT THE FOOT CENTER OF NEW YORK.
 2.) I APPROVE OF A COPY OF THIS AUTHORIZATION BEING USED INSTEAD OF THE ORIGINAL.
 3.) I REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME OR TO THE PARTY NAMED ABOVE WHO ACCEPTS ASSIGNMENTS.
 4.) I AUTHORIZE THE FOOT CENTER OF NEW YORK TO RELEASE MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO MEDICARE, ITS INTERMEDIARY, OR OTHER COMMERCIAL INSURANCE COMPANIES

- SPANISH: 1.) YO, _____, ESTOY DE ACUERDO EN TOMAR RESPONSABILIDAD TOTAL POR TODOS LAS CUENTAS Y POR TODOS LOS SERVICIOS BRINDADOS A MI EN FOOT CENTER OF NEW YORK
 2.) ACEPTO UNA COPIA DE ESTA AUTORIZACION SIENDO USADA EN LUGAR DE ESTE ORIGINAL
 3.) REQUIERO PAGO DE LOS BENEFICIOS MEDICOS A MI O A LA OTRA PERSONA NOMBRADA QUIEN ACEPTA ASIGNACION
 4.) AUTORIZO A FOOT CENTER OF NEW YORK DE DAR INFORMACION MEDICA Y OTRA INFORMACION ACERCA DE MI A MEDICARE, SU INTERMEDIARIO O A CUALQUIERA OTRA COMPANIA COMERCIAL DE SEGUROS

SIGNATURE AND DATE / FIRMA Y FECHA

WITNESS TO SIGNATURE / TESTIGO A FIRMA

REGISTRATION COMPLETED BY

CODE

<input type="text"/>	<input type="text"/>
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