

Please Print

Last Name	First Name	MI	Today's Date
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Street Address (including Apt or Suite #):

City, State & Zip:

Home Phone	Birthdate	Gender M F	Soc Sec # (req'd for ID purposes)
Cell Phone			

Marital Status:	Single	Married	Divorced	Widowed	Partnered
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Employer	Occupation	Work Phone
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Emergency Contact Name & Relationship to Patient
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Emergency Contact Phone	Who referred you to us?
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Person responsible for payment (if the patient is a minor or is incapacitated)

Name:	Phone:
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SS#:	Employer:
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PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST FOR COPYING
We will not be able to file your insurance for you without a copy of your card
Policyholder (if other than patient)

Name:	Birthdate:
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SS#:	Employer:
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Consent for treatment: The undersigned hereby grants authorization for treatment and procedures that are deemed necessary by his/her physician. The undersigned is aware that the practice of medicine is not an exact science and acknowledges that no guarantees have been made as to the results of treatment rendered. **Release of information:** The undersigned hereby authorizes Piedmont Podiatry to release to third party payers information regarding his/her examination or treatment for purposes of obtaining insurance compensation, precertification or medical records. **Irrevocable assignment of insurance benefits:** The undersigned hereby irrevocably assigns and authorizes payment directly to Piedmont Podiatry otherwise payable to him/her, but not to exceed the balance due for the charges rendered. The undersigned understands that the agreement does not relieve him/her of any responsibility for charges not covered by this authorization. **Cancellation fee:** The undersigned hereby acknowledges that he or she may incur a fee if a scheduled appointment is not cancelled in a timely manner.

Financial agreement: For and in consideration of the medical services and goods rendered by Piedmont Podiatry, the undersigned agrees to make payment in full immediately upon receipt of final billing. **Non-covered services:** The undersigned hereby understands that his/her insurance company may deem certain medical procedures, diagnostic studies and goods obtained from this office as a non-covered item and deny payment. Such charge would then become the undersigned's responsibility.

By signing below, I certify that all information above is correct to the best of my knowledge, and that I have read and understand the above stipulations.

Signature

Date
