

Albemarle-Charlottesville Podiatry Associates, Ltd

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Welcome to our practice

Date: _____

Acct. No.: _____

Patient Information				Please Print		
Last Name,	First Name	M.I.	Social Security Number	Sex	Age	Date of Birth
Address			City	State	Zip	
Home Phone ()	Work Phone ()	Cell Phone ()		Marital Status		
Occupation	Patient Employed By	Employer's Address				
Spouse			Date of Birth			
Occupation	Spouse Employed By	Employer's Address				
In case of an emergency, please notify:			Phone ()			

Insurance Information (Please present your insurance card and/or referral to the receptionist)			
Primary Insurance Company	Policy Number	Group Number	
Secondary Insurance Company	Policy Number	Group Number	
If the patient is a minor, please complete the following...			
Parent / Guardian Name	Relationship	Social Security Number	Date of Birth
Employer's Name		Employer's Address	

INSURANCE AND PAYMENT POLICY

- Patients are financially responsible for all charges to their account.
- Patients are responsible for insurance referrals.
- Our office **DOES ACCEPT ASSIGNMENT** on Blue Cross/Blue Shield, Key Care, as well as Medicare, and Medicaid. However, you are responsible for any and all deductibles, co-payments, and any non-allowed charges (such as shoes and shoe inserts, casts, braces, supplies, etc.)
- Our office **DOES ACCEPT ASSIGNMENT** on all services covered by Medicare. However, **MEDICARE DOES NOT COVER TRIMMING OF NAILS, CORNS, AND CALLUSES.** Therefore, you will still have to pay for this service at the time of the visit.
- **There is a \$35.⁰⁰ service charge for any returned checks.**

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits to Albemarle-Charlottesville Podiatry Associates, Ltd., as agreed upon at the time of treatment for services rendered. If my account becomes assigned to a collection agency, I agree to pay all costs of collection, including 25% agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 per cent late charge per month on the unpaid monthly balance.

Signature: _____ Date: _____