WELCOME TO OUR OFFICE

Albemarle Family Foot & Ankle

Bryan R. Snyder, DPM, FACFAOM *Heather Snyder, DPM, FACFAOM*

Patient Information

Last Name:	First Name:	Middle:	Sex: *(circle one)* M F
Mailing Address:	City:	State:	Zip:
E-Mail:	Cell Phone:	Home Phone:	
Preferred method of contact: *(circle one)* Email Cell phone Home phone	Social Security #:	Date of Birth:	
Preferred Name or Nickname:	Marital Status: *(circle one)* Single Married Divorced Widowed Other		
Employer:	Occupation:	Status: *(circle one)* F/T P/T Retired	
Work Address:	Work Phone:		
Ethnicity: *(circle one)* Non-Hispanic Hispanic Not Specified	Preferred Language:		
Race: ❑ Caucasian or European American ❑ African or African American ❑ Asian or Asian American ❑ Native American or Native Alaskan ❑ Native Hawaiian or Pacific Islander ❑ Other_____			

How did you hear about us? ❑ Yellow Pages ❑ Internet ❑ Insurance company ❑ Martha Jefferson Hospital
❑ Doctor_____ ❑ Patient_____ ❑ Other_____

Responsible Party (Guarantor) Information (if other than patient)

Last Name of Responsible Party:	First Name:	Middle:	Sex: *(circle one)* M F
Patient Relationship to the Responsible Party: *(circle one)* Self Spouse Child Other	Social Security #:	Date of Birth:	
Billing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Employer:	Work Phone:		

Important Contacts

Primary Care Physician:	Phone:	****Date of Last Visit:**
Preferred Pharmacy:	Pharmacy Location:	
Emergency Contact:	Relationship to Patient:	Phone:

Insurance Information *****A copy of your insurance card and photo ID is required!*****

Primary Insurance Company:	Secondary Insurance Company:
Subscriber Name:	Subscriber Name:
Insured's D.O.B.:	Insured's D.O.B.:
Patient Relationship to Subscriber: *(circle one)* Self Spouse Child Other	Patient Relationship to Subscriber: *(circle one)* Self Spouse Child Other
Policy #: Group #:	Policy #: Group #:
Group Name:	Group Name:
Specialist Copay Amount: $	Specialist Copay Amount: $

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Assignment and Release / Financial Agreement

Please be advised that certain items and services necessary to provide you with optimum foot care are generally NOT covered by Medicare or other insurance carriers.

Some examples of non-covered services include:

- Routine foot care, including the cutting or removal of corns and calluses, and the trimming, cutting, clipping, or debriding of toenails
- Evaluation and treatment of flat feet or bunions, including the prescription of supportive devices (orthotics)
- Certain supplies, including supportive devices (orthotics/ insoles), splints, paddings, or medications dispensed by this office

All health plans are not the same and do not cover the same services. Despite our best efforts to contact your insurer prior to your visit to inquire about podiatry benefits, your insurer may deny payment for certain items or services rendered in this office. If my insurer denies payment, I agree to be personally and fully responsible for the payment of these items or services. Payments for "non-covered" services rendered and/or for supplies dispensed are due at the time of service. The office accepts VISA, MasterCard, Discover, cash or check. _____**Initials**

We will require a copy of your insurance card(s) and/or photo identification for our records. Without an insurance card or proper identification, we will be unable to file your insurance claim, and you will be responsible for the full amount of the charges accrued for the day. You must inform the office of any changes in your demographic or insurance information. In the event the office is not informed or any changes in my insurance or demographic information, I agree to be responsible for any charges denied by my insurance company. _____**Initials**

I understand that my insurance policy is a contract between me and my insurance company. As a service to me, the office will file my insurance claim on my behalf. If my insurance company does not pay the practice within 60 days, I agree to be financially responsible for all charges. If the practice later receives a check from my insurer, the practice will refund any overpayment to me. _____**Initials**

I am aware that it is my responsibility to obtain a *valid* referral from my primary care provider should my insurance coverage require it. If I do not obtain a proper referral, or if my referral expires during my course of my treatment, I understand that my insurer may not pay for services rendered. As such, I agree to be financially responsible for all charges. _____**Initials**

I understand that all accounts with a balance over 60 days will be assessed a **$5.00 rebilling fee** per billing statement until my balance is paid in full. There will be a **$25.00 surcharge** added to my account for any returned checks. If my account becomes assigned to a collection agency, I agree to pay all costs of collection, including agency fees, court costs, and attorney fees. I understand that my insurance coverage does not cover any of these fees. _____**Initials**

A patient may return any defective or ill-fitting durable medical good or product dispensed by this office within five (5) days from the date of service. Custom-made or special order items are NOT returnable. I understand that the issue may be remedied by replacing the product, adjusting or modifying the product, or accepting the product for a return with a credit issued for the full amount. _____**Initials**

We do our best to keep on schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, we reserve the right to reschedule your appointment so that other patients are not inconvenienced. We ask that you give us the courtesy of a 24-hour advance notice if you can not keep your scheduled appointment. I understand that a **$50.00 missed appointment fee** will be charged to my account for each missed scheduled appointment not canceled with at least a 24-hour notice. _____**Initials**

I, the undersigned, assign directly to Albemarle Family Foot & Ankle, P.L.L.C. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize any holder of medical information about me to release all information needed in order to secure the payment of benefits. **I understand that I am financially responsible for all charges whether or not paid by my insurance**. I authorize use of this signature on all insurance submissions. This authorization is valid for current and subsequent treatment unless I submit a written revocation.

Signed_____ **Date**_____