adler podiatry clinic+

Patient Name Date of Birth **Age:** ☐ **M** ☐ **F**

Social Security **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Billing Address

Home Phone **Work Phone** **Cell Phone**

Patient's Email:

I agree to receive notifications from Adler Podiatry Clinic, PLLC using the following:
☐ **email** ☐ **mobile text** ☐ **voice messaging**

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired

Employer Name, Address & Phone:

Student ☐ Full Time ☐ Part Time

Emergency Contact: **Phone:** Relation:

Pharmacy Name: **Phone:** **Primary Physician:**

Spouse's Name or Responsible Party **Phone**

Insurance Information:

Primary Insurance Name Subscriber's (Insured) Name

Subscriber's Social Security Date of Birth:

Member ID Group name & number

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Significant Other ☐ Child

Secondary Insurance Name Subscriber's (Insured) Name

Subscriber's Social Security Date of Birth

Member ID Group name & number

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Significant Other ☐ Child

adler podiatry clinic

I request that payment of authorized benefits be made to Adler Podiatry Clinic, PLLC for services rendered. I authorize release to the indicated insurance carrier any medical information needed to determine payments for related services.

I hereby agree to pay Adler Podiatry Clinic, PLLC in a timely fashion, for all services rendered. This includes all co-payment and deductibles as well as any insurance payments that I may receive as a result of services rendered.

In the event your check is returned there will be a fee of $40.00. Payment must be made by; cash or credit card upon returning to the office. Failure to make payment good within 3 business days will result in account being turned over to state attorney's office.

In the event that your account becomes delinquent, you will be held responsible for any collection and/or attorney fees.

I understand that if I cancel my office visit without giving a 24 hour notice, I will be billed a fee of $35.00. For any testing or surgical procedure I understand that the cancellation policy is 5 business days and the fees vary from $50.00 - $200.00 depending on the type of appointment missed. This charge is not covered by the insurance company and will not be waived under any circumstances.

In the event Adler Podiatry Clinic, PLLC should refer me to another Physician, I authorize the release of the above information along with any medical documentation deemed necessary by Adler Podiatry.

I acknowledge that the Notice of Privacy Practices and the Financial Policy are posted and that I have read (or have been given the opportunity to read) and fully understand the notices.

Signature Date

Please Print Name:

Email: myfootdoctor@adlerpodiatry.com Fax to: (904) 731-9270 or Bring to Your Appointment

Patient Account Number _____