Adler Podiatry Clinic, PLLC.
3636 University Boulevard S, Bldg. C
Jacksonville, FL 32216

Complete and Fax (904) 731-9270
Mail or Bring to Next Appointment

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 via the following:
☐**email** ☐ **mobile text** ☐ **voice messaging**

Student Status: ☐Full Time ☐Part Time **Employment Status**: ☐Full Time ☐Part Time ☐Unemployed ☐Reti

Employer Name, Address & Phone: ____

Emergency Contact: ______________________________ **Phone:** ____________________ **Relation:**____________

Pharmacy Name: _________________________________ **Phone:** ____________________

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

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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: ____________________________________

Patient Account Number