Insurance Information

Patient's Primary Insurance

Name of Company _____ Policy Holder's Name _____

Group # _____ Policy ID # _____

Patient s Secondary Insurance (If Applicable)

Name of Company _____ Policy Holder's Name _____

Group # _____ Policy ID # _____

Complete this section if someone else is the Primary Policy Holder

Responsible Party _____ Relationship to patient _____ Legal Guardian _____

Social Security # _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone # (___) _____ Work Phone # (___) _____

Employer _____ Occupation _____ Length of Employment _____

Phone # (___) _____ City _____ State_____ Zip _____

Workers Compensation Claims

Referred By Doctor _____ Date of Accident _____

Employer (at time of accident) _____ Employer's Phone # (___) _____

Claim # _____ Name of Insurance carrier: _____

Adjuster's Name _____ Phone # (___) _____

Our office will file the insurance claims for medical and surgical charges. Self-Pay patients require payment on the date of service. Please remember, you are responsible for all fees, regardless of insurance coverage & all charges if a referral for HMD plans is not obtained prior to date of service.

I authorize the release of any medical information to process insurance claims.

I authorize payment directly to Loveland Foot and Ankle Clinic, P.C. dba Advanced Foot and Ankle Care (AFAC) for medical and/or surgical benefits, if any, otherwise payable to me for the services as described, realizing that I am responsible to pay for non-covered services.

I have reviewed, understand and consent to the Financial Policies of Loveland Foot and Ankle Clinic, P.C. dba AFAC.

Signature of Patient or Legal Guardian _____ Date _____