



CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT

PATIENT INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU?: _____
LAST NAME: _____ FIRST NAME: _____
ADDRESS: _____
CITY _____ ST _____ ZIP _____ HM PHONE: _____
DATE OF BIRTH: ____/____/____ SEX: _____ SS# _____ MARITAL STATUS: SINGLE MARRIED OTHER
EMPLOYER: _____ WK PHONE: _____
EMERGENCY CONTACT: _____ CAN THEY HAVE ACCESS TO YOUR INFORMATION?: YES NO
Name & Phone

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____
ADDRESS: _____
CITY: _____ ST _____ ZIP _____
PHONE: _____
INSURED PERSON: _____
ADDRESS: _____
CITY: _____ ST _____ ZIP _____
EMPLOYER: _____
SS # _____
ID# _____
GROUP/POLICY # _____
SEX: _____ MARITAL STATUS: _____ BIRTH DATE: ____/____/____
RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____
ADDRESS: _____
CITY: _____ ST _____ ZIP _____
PHONE: _____
INSURED PERSON: _____
ADDRESS: _____
CITY: _____ ST _____ ZIP _____
EMPLOYER: _____
SS #: _____
ID# _____
GROUP/POLICY#: _____
SEX: _____ MARITAL STATUS _____ BIRTH DATE: ____/____/____
RELATIONSHIP TO PATIENT: _____

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE HEATHER MCCOMBS, DPM LLC TO USE MY HEALTH CARE INFORMATION & DISCLOSE SUCH INFORMATION TO APPROPRIATE INSURANCE(S) & THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES & DETERMINING INSURANCE BENEFITS. I AUTHORIZE HEATHER MCCOMBS, DPM LLC TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MEDICAL & OTHER PERSONNEL WHO MAY PARTICIPATE IN MY CARE. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL I REVOKE SAID AUTHORIZATION BY GIVING WRITTEN NOTICE.

(SIGNATURE PATIENT OR PARENT IF MINOR) DATE _____

AUTHORIZATION OF PAYMENT TO PHYSICIAN

I HEREBY ASSIGN ALL INSURANCE BENEFITS DIRECTLY TO HEATHER MCCOMBS, DPM LLC, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY LIABLE FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE PAYMENT. HEATHER MCCOMBS, DPM LLC DOES NOT WAIT FOR SETTLEMENT FROM LAWSUITS. YOU ARE RESPONSIBLE FOR PAYING FOR SERVICES WHILE IN LITIGATION.

(SIGNATURE PATIENT OR PARENT IF MINOR) DATE _____

CANCELLATION POLICY

BY SIGNING BELOW, I UNDERSTAND THAT APPOINTMENT CANCELLATIONS MUST BE DONE BY 4:30 PM THE BUSINESS DAY PRIOR TO MY SCHEDULED APPOINTMENT. IF I FAIL TO DO SO, I WILL BE CHARGED FOR A NO-SHOW FEE OF \$25.00. HEATHER MCCOMBS, DPM LLC RESERVES THE RIGHT TO CHARGE FOR NO-SHOW APPOINTMENTS & RESERVES THE RIGHT TO CHANGE THIS POLICY AT ANY TIME.

(SIGNATURE PATIENT OR PARENT IF MINOR) DATE _____

HIPPA

BY SIGNING BELOW, I HAVE RECEIVED & READ THE HIPPA PRIVACY INFORMATION SHEET THAT WAS PROVIDED TO ME.

(SIGNATURE PATIENT OR PARENT IF MINOR) DATE _____

COLLECTION FEES

I ACKNOWLEDGE THAT IF MY ACCOUNT IS TURNED OVER TO COLLECTIONS, I WILL BE RESPONSIBLE FOR ANY COST, FEES, AND ATTORNEY FEES INCURRED IN COLLECTIONS TO OBTAIN PAYMENT FOR SERVICES RENDERED.

(SIGNATURE PATIENT OR PARENT IF MINOR) DATE _____