

Area Wide Foot and Ankle Center

1967 Spruce Hills Drive
Bettendorf, IA. 52722

Phone (563) 441-0117

Welcome New Patient / Insurance Information

Last Name _____ First Name _____ Middle initial _____ Birth Date _____

Street _____ City _____ State _____ Zip _____ Age _____

Home Phone (_____) _____ Cell Phone Number (_____) _____

Marital Status: Single Married Separated Divorced Widowed Social Security No. _____

Employer _____ Occupation _____ Length at this job _____

Employer address _____ City _____ State _____ Zip _____ Work Phone _____

Name of Spouse or Parent _____ Social Security No. _____ Birth Date _____

Address _____ City _____ State _____ Zip _____ Phone number _____

Spouse or Parent's Employer _____ Work Number _____

Person to notify in case of an emergency:

Name _____ Relationship _____ Home Phone _____

Street _____ City _____ State _____ Zip _____ Work Phone _____

Insurance information:

Who is responsible for payment of this account: _____ Relationship of this person to you: _____

Insurance 1

Name of Insured _____
Birth Date of Insured _____
Insured Soc. Sec. No. _____
Name of Company: _____
Address of Company: _____
Group Number _____ Policy Number _____

Insurance 2

Name of Insured _____
Birth Date of Insured _____
Insured Soc. Sec. No. _____
Name of Company: _____
Address of Company: _____
Group Number _____ Policy Number _____

Consent to Treat and Confidential Communications

I consent to have Dr. James Licandro/Area Wide Foot and Ankle Center to treat myself/family member for podiatry services.
I request that all written or oral communications to me (by telephone, mail or otherwise) by Area Wide Foot and Ankle Center and/or its staff be handled by using the above address and telephone number. I am responsible to notify the office of any change of above. May we leave a message? YES _____ NO _____

Responsible party signature _____ Relationship _____ Date _____

For practice use only: Accepts _____ Denies _____ Privacy Officer Signature _____ Date _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr. James Licandro all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature in all insurance submissions.

Responsible party signature _____ Relationship _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. James Licandro for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsure and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____