FootWorks
Podiatry & Laser, Inc.

INSURANCE INFORMATION/FINANCIAL POLICY

Insurance:_____ I.D. Number_____ Group Number: _____
Primary Card Holder _____Date of Birth _____Relationship _____

Your insurance policy dictates your coverage for treatment and payment. **Please note that you are responsible to understand your specific insurance coverage- including deductible and co-pay**. FootWorks Podiatry & Laser, Inc. does not assume any responsibility for verifying insurance coverage, co-payment, or deductible.

I agree that I am financially responsible for all claims due to FootWorks Podiatry & Laser, Inc. If my primary, secondary and/ or tertiary insurance coverage changes or if payment/ coverage is denied, I understand that I am financially responsible for any amount not covered. ***Initials:*** _____

I understand that FootWorks Podiatry & Laser, Inc. may charge to my account 6% penalty per month on any unpaid balance. If you have a co-payment, it is due at the time of service.
It has been determined that your co-payment is: _____.

I have read and understand the foregoing and agree to abide by the provisions of this disclaimer.

Signature Patient/Guardian:_____ Date:_____

THERE IS A 24 HOUR CANCELLATION REQUIREMENT. YOU WILL BE CHARGED $40 FOR MISSED APPOINTMENTS OR LATE CANCELLATIONS. ***Initials:*** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read) and understand the Notice.

- **How may we communicate with you to discuss your healthcare?**
  Phone: Yes No Preferred Number: _____Voice mail? Yes No
  Email: Yes No Text: Yes No
- **May we discuss your medical condition with any member of your family?** Yes No
  If YES, please give name/phone:_____
- **I give my consent to have photographs or video images taken of my feet/nails to document care**. Yes No

Patient/Guardian Name (please print):_____

Signature Patient/Guardian:_____ Date: _____

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