

FRIENDLY FOOT CARE, P.A.

Mark E. Landry, D.P.M., M.S.

WELCOME TO OUR OFFICE

IN ORDER TO FACILITATE TREATMENT PLEASE ANSWER THE FOLLOWING QUESTIONS

PATIENT INFORMATION

TODAY'S DATE _____

Patient's Full Name _____ Marital Status S ___ M ___ W ___ D ___

Social Security# _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Business Phone () _____

Employer _____ Occupation _____

Employer Address _____

FAMILY INFORMATION

Nearest Relative _____ Relationship _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Business Phone () _____

Employer _____ Occupation _____

Employer Address _____

RESPONSIBLE PARTY (if patient is a minor)

Name _____ Relationship to patient _____

Social Security # _____ Address _____

City _____ State _____ Zip _____

Employer _____ Address _____ Phone _____

How or by whom were you referred to our office?

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of any medical information necessary to process the claim(s) and I hereby authorize my insurance company to send direct payment of medical benefits to the undersigned.

**FRIENDLY FOOT CARE, P.A.
10550 QUIVIRA ROAD, SUITE 260
OVERLAND PARK, KS 66215**

Signature of Insured _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OFFICE VISIT COPAYS BE PAID BEFORE YOUR VISIT.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private insurance, and other health plans to FRIENDLY FOOT CARE, P.A.

This Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed _____ Date _____

Responsible Party _____ Date _____