

# The Foot and Ankle Wellness Center of Western Pennsylvania

## Patient Information

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Age: \_\_\_\_\_

Sex \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status:  S  M  W  D

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cellular Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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*If the patient is a **minor**, please give name of parent or guardian, who is financially responsible for billing*

Name of spouse/Parent: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's/Parent's Employer: \_\_\_\_\_ Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext.: \_\_\_\_\_

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### Occupation

Patient's Occupation: \_\_\_\_\_ Patient Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext.: \_\_\_\_\_

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### Other Information

Primary Care Physician Name and Address: \_\_\_\_\_

How were you referred to our office?  Primary Care Physician  Another Physician (Name : \_\_\_\_\_)

Yellow Pages  Friend or Relative  Health Insurance Company  Other: \_\_\_\_\_

In *Case* of emergency notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cellular Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*The Foot and Ankle Wellness Center of Western Pennsylvania*

Insurance Information

Primary Company: \_\_\_\_\_ Secondary Company: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ Insurance Co. Address: \_\_\_\_\_

\_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Guarantor's Name: \_\_\_\_\_ Guarantor's Name: \_\_\_\_\_

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Accident Information

Accident Related To:  Work  Auto  Other: \_\_\_\_\_

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Location of Injury: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Responsible Party's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Responsible Party Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext.: \_\_\_\_\_

Brief Description of the Injury: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY FOR YOUR FILE**

*The Foot and Ankle Wellness Center of Western Pennsylvania*

Assignment of Benefits

**THE FOLLOWING IS REQUIRED BY LAW:  
PLEASE READ CAREFULLY AND SIGN**

I request and authorize **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo**, to release any information to the Health Care Financing Administration, Medical Assistance and my insurance company required to process my healthcare claim for services rendered by **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo**. I understand my signature authorizes **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo & Staff** to examine and treat me including x-rays; I also understand payment for services or items could be for federal and/or state laws.

I hereby request payment be made directly to **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo**, by authorizing Medicare, Medical Assistance, and/or all other insurance companies for any and all services rendered to me through **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo**.

**I understand I am personally responsible for all charges which Medicare, Medical Assistance and/or any other insurance company may or may not pay, including but not limited to co-insurance, co-payments, deductibles and non-covered services.** I agree to make payment in full within 30 days of receipt of billing. Aged account balances may forward for collection with additional fees being incurred. Finally, I understand and agree this authorization will remain in effect until such time I request, in writing, termination of this authorization.

Patient Name: (please print) \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

◆ **NOTICE:** If you received podiatric care by another physician within the past 61 days, **MEDICARE** may not pay for these services and you will be responsible. ◆