# AKAMAI FOOT DOCTOR, LLC

| ACCT # | TYPE | DR# | DATE |
|---|---|---|---|
| | | | |

**PATIENT**

**** ARE YOU BEING SEEN TODAY FOR A WORK-RELATED INJURY? ( )YES ( )NO. IF "YES," PLEASE INFORM OUR STAFF AT THIS TIME. ****

| LAST NAME | FIRST NAME | M.I. |
|---|---|---|
| | | |

| SEX ( )M ( )F | SOCIAL SECURITY NO. | BIRTHDATE | MARITAL STATUS ( ) | ( )Single ( )Married ( )Divorced ( )Widowed |
|---|---|---|---|---|
| | | | | |

| ADDRESS | UNIT/APT | HOME PHONE |
|---|---|---|
| | | |

| CITY | STATE | ZIP | CELL PHONE |
|---|---|---|---|
| | | | |

| EMPLOYER NAME/ADDRESS | WORK PHONE |
|---|---|
| | |

| GUARANTOR NAME/ADDRESS (financially-responsible party) IF DIFFERENT FROM PATIENT | GUARANTOR PHONE |
|---|---|
| | |

| SPOUSE NAME | PATIENT/GUARANTOR EMAIL |
|---|---|
| | |

| EMERGENCY CONTACT NAME/ADDRESS | EMERGENCY PHONE |
|---|---|
| | |

| REFERRING DOCTOR | PRIMARY CARE DOCTOR (if different from referring) |
|---|---|
| | |

IF DOCTOR(S) OUT-OF-STATE, PLEASE PROVIDE ADDRESS/PHONE

**MINOR**

| PARENT/GUARDIAN NAME | RELATIONSHIP TO PATIENT | MARITAL STATUS ( )Single ( )Married ( )Divorced ( )Widowed ( ) |
|---|---|---|
| | | |

| CELL PHONE | HOME PHONE | WORK PHONE | CHILD/MINOR SCHOOL NAME |
|---|---|---|---|
| | | | |

| PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD | RELATIONSHIP TO PATIENT |
|---|---|
| | |

**INSURANCE**

| PRIMARY INSURANCE NAME: | SUBSCRIBER NAME | SEX ( )M ( )F | BIRTHDATE |
|---|---|---|---|
| Address: | SUBSCRIBER EMPLOYER | RELATIONSHIP TO PATIENT | |
| Phone: | POLICY NUMBER/SUBSCRIBER SS# | | EFFECTIVE DATE |
| SECONDARY INSURANCE NAME: | SUBSCRIBER NAME | SEX ( )M ( )F | BIRTHDATE |
| Address: | SUBSCRIBER EMPLOYER | RELATIONSHIP TO PATIENT | |
| Phone: | POLICY NUMBER/SUBSCRIBER SS# | | EFFECTIVE DATE |
| TERTIARY INSURANCE NAME: | SUBSCRIBER NAME | SEX ( )M ( )F | BIRTHDATE |
| Address: | SUBSCRIBER EMPLOYER | RELATIONSHIP TO PATIENT | |
| Phone: | POLICY NUMBER/SUBSCRIBER SS# | | EFFECTIVE DATE |

| DATE OF INJURY/ONSET | CONDITION(S) YOU ARE SEEKING TREATMENT FOR TODAY |
|---|---|
| | |

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: I authorize Dr. Nathalie** Sowers and AKAMAI FOOT DOCTOR, LLC and its representative to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

**FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by said insurance.** These include deductible, co-payment, cost-share, and/or non-covered benefits. I also understand that without proof of coverage, I am financially responsible for charges *at the time of service,* including, but not limited to, preliminary payment for a consult/visit charge payable by cash or credit card only. I agree to pay a late payment fee of 1% a month on any unpaid balance over 180 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I also agree to pay a $25 processing fee for each returned check.

**I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used on place of** the original. This authorization is valid until revoked by me in writing.

**Patient/Parent/Guardian Signature** **Relationship to Patient** **Date**