Chesapeake Family Foot Care, PA
611 Dutchmans Ln
Easton, MD 21601
410-822-0991, fax 410-822-0577

Patient Name_____ Facility:_____

Insurance information must be completed. Please attach copy of current insurance cards and facility face sheet if applicable. Please indicate priority of insurance.

Primary insurance _____ ID/Policy#_____

Policy Holder Name_____ DOB_____ Group#_____

Secondary insurance_____ ID/Policy#_____

Policy Holder Name_____ DOB_____ Group#_____

Payment Policy

Payment in full or applicable co-payment is required for plans with which we participate at the time services are rendered. If you have insurance through one of the plans with which we participate, be sure we have your correct insurance information. Unless we participate with your insurance plan, payment in full is expected at time of service. If we participate with your insurance plan any applicable co-payment is expected. If you don't have an insurance plan with which we participate and are unable to pay at the time of service, please make arrangements with the office staff. We will make every effort to arrive at a mutually agreeable payment plan.

Payment in full is required for all services rendered and not covered by third party payer by the patient, undersigned and/or responsible party at time of service.

A fee for any missed appointments will be assessed and must be paid by the patient, undersigned and/or responsible party unless 24 hours notice if given.

If all attempts to collect reasonable amounts due fail and this account has to be referred to a collection agency for action, the patient, undersigned and/or responsible party agrees to pay the full cost of collection, including attorney's fees agency fees, court costs, filing fees, and interest as allowed by law.

Initials_____

Notice of Privacy Practices

The patient and/or responsible party acknowledges receipt of attached Privacy Practice Notice.

Initials_____

Authorization for Treatment and Release of Information

I hereby grant authority to Chesapeake Family Foot Care and it's employees to administer necessary medical treatment to me, my charge, my dependent minor or student family member. Further I authorize disclosure of complete medical information, including records concerning my illness or injury for the purpose of insurance processing or consultations as necessary.

Initials_____

Patient, POA or responsible party: _____ POA Phone_____
(print name)

POA Billing EMAIL_____

POA Billing Address:_____

Signature _____ Date_____ Witness _____Date_____
(circle) Patient Parent POA Responsible party