

WELCOME TO OUR OFFICE

TODD C. SKILES, DPM, FACFAS
MARYSVILLE FOOT & ANKLE CLINIC

(Patient Info
Please Print)

PATIENT NAME _____ DATE of BIRTH _____ AGE _____ M _____ F

ADDRESS _____ CITY / STATE / ZIP _____

HOME PH# _____ CELL PH# _____ SPOUSE'S NAME _____

SS# _____ EMPLOYER _____ WORK PH# _____

WORK ADDRESS/CITY/STATE/ZIP _____

(Check One) MARRIED SINGLE MINOR SEPERATED DIVORCED WIDOWED

(if different from above)

NAME OF INSURANCE POLICY HOLDER (husband. wife. Parent) _____

ADDRESS/CITY/STATE/ZIP _____

DATE OF BIRTH _____ SS# _____ EMPLOYER _____

(Work)

ADDRESS/CITY/STATE/ZIP _____ WORK PHONE# _____

EMERGENCY CONTACT PERSON

NAME _____ RELATIONSHIP TO YOU _____ PHONE# _____

INSURANCE INFORMATION: (Please provide current insurance. card for copying. If no card, fill information in blanks provided. Thank you.)

*PRIMARY INSURANCE NAME _____

POLICY & GROUP NUMBERS _____

(PATIENT'S RELATIONSHIP TO INSURED) SELF SPOUSE CHILD OTHER _____

*SECONDARY INSURANCE NAME _____

POLICY & GROUP NUMBERS _____

(PATIENT'S RELATIONSHIP TO INSURED) SELF SPOUSE CHILD OTHER _____

WHO IS YOUR PRIMARY CARE PHYSICIAN: _____

HOW DID YOU HEAR ABOUT OUR OFFICE'?

VERIZON YELLOWPAGES INTERNET FRIEND SIGN PROVIDER MANUAL OTHER _____

Cont

CONSENT FOR TREATMENT: GIVE MY PERMISSION TO DR. TODD C. SKILES TO ADMINISTER TREATMENT, INCLUDING XRAYS, INJECTIONS AND SUCH PROCEDURES AS MAY BE DEEMED MEDICALLY NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND/OR TREATMENT OF THE FOOT AND RELATED CONDITIONS.

ASSIGNMENT AND RELEASE: I authorize: any insurance: co., hospital. health care provider, organization or employer to release any information requested with regard to processing my claim and payment of medical benefits to Dr. Todd C. Skiles for professional services rendered. I certify that the information I furnish is true and correct.

PAYMENT OF BENEFITS: As a courtesy, we will bill your insurance, as long as proof of coverage is provided. I understand that I am responsible for the complete payment of medical services not covered by my insurance and payment is expected at the time of service unless special arrangements are: made prior to services being rendered. Payment is expected 30 days after visit or insurance response. I also agree that all charges not paid by my insurance company will be my responsibility.

TERMS: If there is no insurance coverage, arrangements must be made prior to services being rendered. On any unpaid balance due there will be a minimum service charge of \$3.00 per month added to balance. On any NSF checks there will be a \$20,00 charge. If you have any questions or concerns regarding our policies, please ask.

MISSED APPOINTMENTS: A charge of \$25 - \$50 may be charged for a missed appointment without 24 hour prior notice. If a total of three visits are missed you will be referred onto another clinic for further care.

SIGNATURE _____ **PATIENT'S NAME** _____
(please print)

SIGNATURE OF RESPONSIBLE PARTY IF PATIENT IS UNDER AGE 18 **DATE**

MARYSVILLE FOOT & ANKLE CLINIC
TODD C. SKILES, DPM, FACFAS
9516 STATE AVENUE, SUITE D
MARYSVILLE, WA, 98270

INSURANCE COVERAGE DISCLAIMER

As a courtesy we may call your insurance company to verify coverage on any services and/or products which may be needed for your care. There are many different insurance companies with many different types of coverage that we deal with. We will do our best to give you information regarding your coverage as accurately as possible. Please note that every time we call an insurance company we are given a disclaimer, "*this is not a guarantee of coverage*".

By signing this disclaimer you understand this policy and allow us to call your insurance company. You also agree that you are responsible for the complete payment of medical services and/or products that are not covered by your insurance company.

Patient signature

Date

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature