

**Advanced Podiatric Specialists**  
1389 West Main Street \* Suite 222  
Waterbury, CT 06708  
Phone (203) 757-9200 \* Fax (203) 757-3990

Name \_\_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Age \_\_\_\_\_ Single Married Widowed Divorced (**Circle one**)

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Emergency Contact Name** \_\_\_\_\_ Relationship to you \_\_\_\_\_ Daytime phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ Copay Amount \$ \_\_\_\_\_ Effective date \_\_\_\_\_

Identification# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy Holder's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Co pay Amount \$ \_\_\_\_\_ Effective date \_\_\_\_\_

Identification# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Policy Holder's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

**DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE**

I hereby name as assignee and also instruct and direct my Insurance Company to pay by check made out and mailed to the assignee: **Dr Charles T Arena / Dr Eric Lui/Dr Sherwin Tucker 1389 West Main Street, Waterbury, CT 06708. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** I grant the assignee a limited Power of Attorney to sign my name, deposit and negotiate any insurance payment received and apply it to my outstanding balance. These payments will not exceed my indebtedness to the above-mentioned assignee. I agree that a photocopy of this Assignment shall be considered as effective as the original. In order that the assignee may submit a claim for payment for services covered under my insurance carrier and vice versa. FOR MEDICARE: I authorize any holder of medical information about me to release, to the Health Care Financing Administration and its agent, any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to you any information regarding my Medicare claims under Title XVIII of the Social Security Act.

X

Date

**Signature of policyholder**

**FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT**

I authorize the Doctor(s), and staff of the practice as named on the reverse side of this form, to treat the patient named on this form and agrees to pay all fees and charges for such treatment. I agree to pay all charges for myself and members of my family per the terms of this agreement. Charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree that the prevailing party will be entitled to reasonable attorney's fees and costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any lawsuits, liens or insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable. I understand that not all services and fees are covered by insurance. I understand that I am responsible for paying all deductibles, co- payments, non-covered services, and any portion of covered services not paid in full by my insurance. Such payments are due at the time of service or immediately upon presentation of the bill. I agree that I shall remain financially responsible for the above named patient until I notify you in writing to the contrary. This guarantee is continuing even if the actual patient, if a minor, reaches the age of majority. I authorize you or your agent to make credit investigation including employment verification. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my (the patient's) health or the above information. This instrument contains the entire and only agreement between the parties and there are no other promises, representations, or warranties, either expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument, in writing, signed by the parties hereto. You are entitled to a copy of this agreement at the time you sign, Keep it to protect your legal rights. **NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ AND AGREED TO THE CONDITIONS SET FORTH ON THIS FORM.** I hereby acknowledge the receipt of a copy of these terms and charges and agree to them as stated and referred to herein.

X

Date

**Signature by Patient (Parent must sign if patient is under 18 years)**