Dr. Aamir Ahmed DPM

Dr. Venkatramesh Medapati DPM

Patient Information

First Name:_____ Middle Initial: ____ Last Name:_____ Date: _____

Street Address:_____ City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____ Ext: ____

E-mail:_____ Date Of Birth:_____ Sex: M F

Referral Source: Family/Friend Insurance Google Doctors Name: _____ Other:_____

Employer Name: _____ Occupation: _____

Policy Holder Information

Policy Holder Last Name: _____First: _____ Middle: ___

Address (If different): _____City:_____ State: ____ Zip:_____

Policy Holder Phone Number: _____ Work Number: _____ Ext: ____

Policy Holder SS#: _____ Policy Holder Date of Birth: _____

Policy Holder Employer Name: _____ Relationship: _____

Emergency Contact Information

Contact Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Explanation of Payment Policy and Insurance Filing Procedures

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of these expenses. We will wait 90 days for your insurance company to pay your claim and if they do not we will give you 30 days to pay the balance.

1. The patient is responsible to pay any deductible and copayments at the time services are rendered.
2. Any portion of a billed amount that is labeled "disallowed" or "over reasonable and customary" will become the patient's responsibility.
3. Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account immediately.
4. We will not file insurance for patients that do not live in Texas. We will provide you with a receipt so you may get reimbursement.

I understand all the above policies and agree to them. I authorize my insurance carriers to pay benefits directly to Footcare Centers on any unpaid services filed on my behalf by Footcare Centers I also understand that Footcare Centers is not ultimately responsible for collecting my insurance or negotiating settlements of claims. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information that is used or disclosed for the purposes of treatment, payment, or health care operations be restricted.Footcare Centers is not bound by the restriction unless it is in agreement with the restriction.

Signature of Patient, Parent or Agent: _____ Date: _____