ADVANCED FOOT & ANKLE CLINIC
3730 PLAZA WAY SUITE 6500
KENNEWICK WA 99338

PHONE: 509-585-3622
FAX: 509-585-3624

PATIENT INFORMATION:

Please Print

PATIENT'S NAME: _____ SEX __ MALE __ FEMALE
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____ APT: ____ CITY _____ STATE ____ ZIP _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY# _____ - ____ - _____

PHONE: (HOME) _____ (WORK) _____ (CELL) _____

E-MAIL _____ EMPLOYER _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION:

NAME: _____ RELATIONSHIP: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____ APT: ____ CITY _____ STATE ____ ZIP _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY# _____ - ____ - _____

PHONE: (HOME) _____ (WORK) _____ (CELL) _____

EMPLOYER: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

PLEASE BE ADVISED THAT STATEMENTS ARE SENT ELECTONICALLY TO YOUR EMAIL OR VIA TEXT MESSAGING.

RESPONSIBILITY FOR PAYMENT OF SERVICES

I hereby authorize my health insurance carrier(s) to make payment of any benefit due me directly to **Dr. Carter**. I acknowledge and understand that I am responsible for all charges for services rendered to me or my dependents, at the time of service, unless prior arrangements have been made. I am responsible for any services not covered by my insurance. I agree to pay any balance owing on my account promptly upon receiving my statement. I agree to pay any attorney fees and collections costs.

I consent to **Dr. Carter** to furnish my insurance company and Medicare any information regarding my care as may be requested. A copy of this agreement is considered as an original for insurance purposes.

*Copays are due at the time of service, or an additional $5 fee will apply.

Advanced Foot and Ankle Clinic reserves the right to charge $20 for established patients that miss their appointments and $50 for new patients. Of course, we understand that extenuating circumstances occur and will take that into consideration. Charges will be made directly to you.

DATE: _____ **SIGNATURE:** _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN