

FOOT AND ANKLE SPECIALISTS
BARRY A. KLEIN, DPM, FACFAS, DABPS
DEBRA B. KLEIN, DPM, FACFAS, DABPS

OFFICE LOCATION (Please check one):

Pine Hill _____

Florence _____

INSURANCE INFORMATION

NAME _____ TODAY'S DATE _____
Last First M.I.

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

ADDRESS _____

RELATIONSHIP _____

PHONE _____ DATE OF BIRTH _____

PRIMARY MEDICAL INSURANCE _____

NAME OF POLICY HOLDER _____ DATE OF BIRTH _____

RELATIONSHIP _____ SS# _____

POLICY # _____ GROUP # _____

IS THIS INSURANCE THROUGH EMPLOYER? _____ YES _____ NO

SECONDARY MEDICAL INSURANCE _____

NAME OF POLICY HOLDER _____ DATE OF BIRTH _____

RELATIONSHIP _____ SS# _____

POLICY # _____ GROUP # _____

IS THIS INSURANCE THROUGH EMPLOYER? _____ YES _____ NO

LIST ANY OTHER MEDICAL INSURANCE COVERAGE _____

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO FLORENCE FOOT AND ANKLE SPECIALISTS / DRs. KLEIN FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN / SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT THE ULTIMATE RESPONSIBILITY FOR PAYMENT OF SERVICES IS BY THE INSURED (CLAIMS ARE FILED AS A COURTESY). THIS INCLUDES PAYMENT OF ANY LATE FEES THAT ACCRUE (AT A RATE OF \$5 PER MONTH) ON OVERDUE ACCOUNTS AS WELL AS REASONABLE ATTORNEY OR COLLECTION FEES IF COLLECTION PROCEEDINGS NEED TO BE INITIATED.

PATIENT'S / GUARDIAN'S SIGNATURE