

Patient Registration Form

Northville Podiatry

Alan J. Bloch, D.P.M., P.L.L.C.

Patient Information

(Please write information about the patient here.)

Patient's Name (Last, First, Middle)	Home Telephone ()	Alternate Daytime Phone Number ()
Address	Marital Status (circle) S M W Sep D	Date of Birth Age / /
City State Zip	Social Security Number	Driver License Number
Emergency Contact Name (at different address)	Emergency Contact Phone ()	Relationship to Patient
What is your occupation?	Employer's Name	Employer's Telephone Number ()

Responsible Party Information

(Please complete below id the person responsible for paying bills is NOT the PATIENT)

Responsible Party's Name (Last, First, Middle)	Telephone ()	Relationship to Patient Spouse Parent Guardian Other
Address City State Zip	Employer's Name	Employer's Telephone

Insurance Information

(Please write information about the patient's insurance here.)

PRIMARY Insurance Company Name	SECONDARY Insurance Company Name
PRIMARY Policyholder's Name (Last, First, Middle) Date of Birth / /	SECONDARY Policyholder's Name (Last, First, Middle) Date of Birth / /
Insured's ID Number Group Plan Number	Insured's ID Number Group Plan Number

Signature _____
(Patient, Parent or Guardian)

Date _____

TO ALL PATIENTS RECEIVING TREATMENT FOR FOOT AND ANKLE CONDITIONS

Please understand that your treatment today will be sent to your insurance carrier.

Financial Responsibility: Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We therefore, urge you, the patient, to please check with your insurance company prior to any office visit/procedure. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient or guardian being responsible for all costs incurred. Delinquent accounts may be subject to collection, service fees. Non-coverage delinquent fees may be subject to a **\$10.00** rebilling fee per month. Please remember your insurance contract is between YOU and your insurance company, not the insurance company and your doctor.

Authorization to Release Information and Assignment of Benefits

1. I hereby authorize Alan J Bloch, D.P.M., P.L.L.C. to apply for benefits on my behalf for any services rendered by that physician or his associates. I request that payment from my insurance company be made directly to:
Alan J Bloch, D.P.M., P.L.L.C.
2. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
3. I certify that the information I have reported with regard to my insurance coverage is correct.
4. In most cases, insurance is accepted as full payment unless otherwise discussed. Patients are responsible for deductibles, co-insurance, copays, and any non-covered charges.
5. This authorization may be revoked by either me or my insurance company at any time in writing.
6. **Please note that most treatments performed in this office are classified as SURGERY by most insurance carriers. This includes cutting of nails, wart treatments, injections, ingrown toenails, strappings, casting, compression wraps (unna boots) and treatment of ulcers, infections.**

I hereby give my permission to Alan J. Bloch, DPM, PLLC & associates to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition(s).

If you have any questions, please feel free to ask.

Signature _____ Date _____
(Patient)

Signature _____ Date _____
(Guardian)