GRAND VALLEY FOOT AND ANKLE CENTER, P.C.

Patient Name _____ SS#_____-_____-_____ Date of Birth _____

Address _____ City _____ State _____ Zip_____

Preferred Phone#: Home _____-_____-_____ Cell _____-_____-_____ Email _____

Age _____ Sex _____ Marital Status _____ Employer _____Occupation_____

Your Primary Care Physician is _____ **Date Last Seen by PCP** _____

Primary Language _____ Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino ____

Race: American Indian or Alaska Native ____ Asian ____ Black or African American ____

Native Hawaiian or Other Pacific Islander ____ White ____

Primary Insurance: _____ **Secondary Insurance:** _____

Subscriber Name (If Different than Patient): _____ **Date of Birth:** _____

Subscriber Mailing Address (If Different than Patient): _____

Subscriber Phone Numbers: Home _____-_____-_____ Cell _____-_____-_____

Responsible Party (If Other than Patient or Under 18 Yrs. Old):
Name_____ Date of Birth _____ Phone Number _____-_____-_____
Address _____ Relationship _____

How did you learn of Grand Valley Foot and Ankle Center?

Physician _____ Social Media/Internet _____ Yellow Pages ____ Insurance Manual____ Newspaper / Mailer ____

Friend/Relative _____ Name of Friend/ Relative _____ Previous Patient_____ Date _____

Is this a **worker's compensation** claim? Yes ____ No ____ If Yes, Date of Injury _____

PLEASE READ CAREFULLY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGES TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CLAIMS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, UNLESS ARRANGEMENTS ARE MADE IN ADVANCE. ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. OFFICE VISITS AND PROCEDURES BILLED TO YOUR INSURANCE COMPANY AND NOT PAID WITHIN 60 DAYS BECOME THE RESPONSIBILITY OF THE PATIENT/GUARDIAN AT AN INTEREST RATE OF 19% PER ANNUM. I AUTHORIZE G.V.F.A.C. TO FURNISH INFORMATION TO MY INSURANCE CARRIERS AND OTHER DOCTORS/HEALTH INSTITUTIONS CONCERNING MY ILLNESS AND TREATMENTS. I HEREBY ASSIGN TO THE DOCTORS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

→_____ **Initial** **Non-payment or Default**: In the event of default or non-payment, any unpaid money owed for services rendered, may be referred to a third party collection agency. The agency we use charges a38% of the unpaid principle balance owed at the time it is turned to them. Those fees become your responsibility. In addition to collection fees, principle and accrued interest, you will also be liable for all attorney's fees and court cost associated with litigation resulting from default.

MEDICAL RECORDS: I UNDERSTAND THAT MY MEDICAL CHART IS THE PROPERTY OF THE PRACTICE AND THAT NO ORIGINAL NOTES OR X-RAYS WILL BE RELEASE. HOWEVER, I UNDERSTAND THAT I HAVE A RIGHT TO ALL INFORMATION IN MY CHART AND THAT INFORMATION WILL BE PROVIDED TO ME WITHIN THREE BUSINESS DAYS ONCE A PROPERLY EXECUTED MEDICAL RECORDS RELEASE HAS BEEN RECEIVED BY THE PRACTICE. I UNDERSTAND THAT THERE WILL BE A CHARGE FOR A COPY OF MY RECORDS AND/OR X-RAYS.

PATIENT / GUARDIAN _____ DATE _____