

Atlanta Center for Foot & Ankle Surgery, LLC

218 Sandy Springs Place , Sandy Springs, Georgia 30328

Telephone: 404-257-0611 Fax: 404-257-1289

Patient Information

Patient Name: _____ Phone: Home: _____ Cell: _____

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

Date of Birth: _____ Social Security: _____ Sex: ____ Race: ____ Marital Status: _____

Employer: _____ Job Title: _____

Employer Address: _____ Work Phone: _____

Person to Contact in Case of Emergency: Name: _____

Address: _____ Phone: _____

Spouse Or Responsible Party Information

Name: _____ Address: _____

Relation to Patient: _____ Date of Birth: _____ Social Security: _____

Employer: _____ Address: _____ Work Phone: _____

Insurance Information

Do you have Medicare? NO YES Do you have Medicaid? NO YES

Was this an on the job injury? NO YES If yes, complete the workers compensation section.

Motor Vehicle Accident? NO YES If yes, please give date of accident: _____

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Phone: _____ Phone: _____

Policyholder: _____ Policyholder: _____

Policy Number: _____ Policy Number: _____

Group # / Adjuster: _____ Group # / Adjuster: _____

For Worker's Compensation Only

Worker's Comp Carrier: _____ Date of Injury: _____

Adjuster's Name: _____ Phone: _____

Mail Claims To: _____

Insurance Authorization & Assignment

I hereby authorize Atlanta Center for Foot & Ankle Surgery, LLC, to furnish information to insurance carriers concerning my surgery and I hereby assign to the facility all payments for medical services rendered to myself or my dependents. I understand that insurance is filed as a courtesy to me and I am responsible for any amount not covered by my insurance.

Responsible Party Signature

Date

Atlanta Center for Foot & Ankle Surgery, LLC

You should expect to receive the following:

1. **Doctor / Surgeon Fee:** This is the fee submitted by the surgeon and covers the actual surgeon's fee and normal postoperative treatments. A deposit may be required before your surgery.
2. **Ambulatory Surgical Center Fee:** This fee represents the charges submitted by the surgical facility and includes operating time, recovery room, surgical supplies, medications and any other special instrumentation. A deposit may be required.
3. **Anesthesia Service Fee:** This is the fee submitted by the anesthesiologist and / or nurse anesthetist and covers those costs involving IV sedation. A deposit may be required.

Assignment of Insurance Benefits

I assign payment of medical, surgical and / or anesthesia benefits directly to the undersigned physician and / or supplier for services rendered.

I understand that my insurance contract is between the insurance company and myself and that the surgery center does not set the amount to be paid by the insurance company, or determine if any payment will be made.

I understand that verification of insurance benefits is not a guarantee of payment from the insurance company.

I understand and agree that after my insurance has been filed, and the insurance company has made payment to the surgery center, I am responsible for the remaining balance.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Insured and / or Patient

Date

Preferred Method of Payment

Cash Check Credit Card (Visa / MasterCard / American Express)