FOOT AND ANKLE CENTER OF NEW JERSEY
SKYBRIDGE HEALTHCARE

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HEALTH INSURANCE INFORMATION

Patient Name_____

Do you have health insurance? Y N

Who is your health insurance carrier? Primary_____Secondary_____

Policy Holder's Name_____ **DOB** _____

If the patient is under 18, who is responsible for the patient's medical bills?

Name_____ **DOB** _____

Address _____

PLEASE READ, SIGN AND DATE THE FOLLOWING INFORMATION

I hereby consent to be treated by the physicians of the Foot and Ankle Center of New Jersey.

I understand that if I do not have insurance coverage, I will be responsible to pay Foot and Ankle Center of NJ on the day of service.

I understand that if my insurance carrier does not pay any amount due for services rendered that I will be responsible for full payment upon request. Such services include but are not limited to: any amount that has been applied to my deductible; any service not approved on my referral (if such form is required by my plan); any service considered to be cosmetic in nature and/or not covered by my insurance plan; any copay or coinsurance designated by my insurance plan.

I am aware that I have a deductible. _____ (please initial)

I understand that if I fail to obtain a referral from my primary care physician when such form is required by my plan, then I will be responsible for payment.

I hereby agree to pay Foot and Ankle Center of NJ for any non-covered services rendered.

I hereby authorize the release of information necessary to file a claim with my insurer, and/or which is pertinent to my case to any insurance company involved with my case, or to my primary care physician if requested. In addition, I authorize payment from Medicare or any other insurance company to be made on my behalf to the above facility.

A copy of this signature is as valid as the original.

X_____Date_____

Signature of patient or patient's guardian