

AKAMAI FOOT DOCTOR, LLC		ACCT #	TYPE	DR#	DATE
**** ARE YOU BEING SEEN TODAY FOR A WORK-RELATED INJURY? ( )YES ( )NO. IF "YES," PLEASE INFORM OUR STAFF AT THIS TIME. ****					
P A T I E N T	LAST NAME		FIRST NAME		M.I.
	SEX ( )M ( )F	SOCIAL SECURITY NO.	BIRTHDATE	MARITAL STATUS ( )Single ( )Married ( )Divorced ( )Widowed	
	ADDRESS			UNIT/APT	HOME PHONE
	CITY		STATE	ZIP	CELL PHONE
	EMPLOYER NAME/ADDRESS				WORK PHONE
	GUARANTOR NAME/ADDRESS (financially-responsible party) IF DIFFERENT FROM PATIENT				GUARANTOR PHONE
	SPOUSE NAME			PATIENT/GUARANTOR EMAIL	
	EMERGENCY CONTACT NAME/ADDRESS				EMERGENCY PHONE
	REFERRING DOCTOR			PRIMARY CARE DOCTOR (if different from referring)	
	IF DOCTOR(S) OUT-OF-STATE, PLEASE PROVIDE ADDRESS/PHONE				
M I N O R	PARENT/GUARDIAN NAME		RELATIONSHIP TO PATIENT	MARITAL STATUS ( )Single ( )Married ( )Divorced ( )Widowed	
	CELL PHONE	HOME PHONE	WORK PHONE	CHILD/MINOR SCHOOL NAME	
	PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD			RELATIONSHIP TO PATIENT	
I N S U R A N C E	PRIMARY INSURANCE NAME:		SUBSCRIBER NAME	SEX ( )M ( )F	BIRTHDATE
	Address:		SUBSCRIBER EMPLOYER	RELATIONSHIP TO PATIENT	
	Phone:		POLICY NUMBER/SUBSCRIBER SS#	EFFECTIVE DATE	
	SECONDARY INSURANCE NAME:		SUBSCRIBER NAME	SEX ( )M ( )F	BIRTHDATE
	Address:		SUBSCRIBER EMPLOYER	RELATIONSHIP TO PATIENT	
	Phone:		POLICY NUMBER/SUBSCRIBER SS#	EFFECTIVE DATE	
	TERTIARY INSURANCE NAME:		SUBSCRIBER NAME	SEX ( )M ( )F	BIRTHDATE
	Address:		SUBSCRIBER EMPLOYER	RELATIONSHIP TO PATIENT	
	Phone:		POLICY NUMBER/SUBSCRIBER SS#	EFFECTIVE DATE	
DATE OF INJURY/ONSET		CONDITION(S) YOU ARE SEEKING TREATMENT FOR TODAY			

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:** I authorize Dr. Nathalie Sowers and AKAMAI FOOT DOCTOR, LLC and its representative to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

**FINANCIAL AGREEMENT:** I understand that I am financially responsible for all charges whether or not paid by said insurance. These include deductible, co-payment, cost-share, and/or non-covered benefits. I also understand that without proof of coverage, I am financially responsible for charges *at the time of service*, including, but not limited to, preliminary payment for a consult/visit charge payable by cash or credit card only. I agree to pay a late payment fee of 1% a month on any unpaid balance over 180 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I also agree to pay a \$25 processing fee for each returned check.

**I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used on place of the original. This authorization is valid until revoked by me in writing.**

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date