

PLAINS PODIATRY ASSOCIATES

Mark A. Barinque, DPM, PA

Social Security # _____ Birth Date _____ Marital Status S M Div Widowed
Last Name _____ First Name _____ M.I. Maiden or Nickname _____
Address _____ Apt. _____
City _____ State _____ Zip _____ E-Mail Address _____
Home Phone # _____ Work Phone _____ Cell Phone _____

Employer's Name _____ Patient's Occupation _____
Address _____ If Student: Full time Part time
City _____ State _____ Zip _____

Please Give Your Insurance Cards To The Receptionist

Do you have health insurance? Yes / No (Please circle one)

Primary Insurance Company Name _____

Please indicate the policyholder for the primary insurance: Self Parent Spouse Other

Secondary Insurance Company Name _____

Please indicate the policyholder for the secondary insurance: Self Parent Spouse Other

Spouse's or Parent's Name _____ Spouse's or Parent's Birth Date _____

Spouse's or Parent's SS# _____ Employer's Phone _____

Spouse's or Parent's Employer _____

Spouse's or Parent's Employer's Address _____

City _____ State _____ Zip _____

Emergency contact : _____ Telephone # _____ Relationship _____

Primary Care Physician's Name: _____ Last visit: _____

Previous Podiatrist: _____ Last visit: _____

How did you find out about us? Advertising (AD) _____ Yellow Pages (YP) _____ Internet (IT) _____ Other _____

Referral by Physician (RP) _____ Family/Friend _____

Name

Name

INSURANCE POLICY

Our practice accepts insurance from all major insurance companies. As a courtesy, our practice will review your insurance coverage, estimate your insurance company payment and file our claim with your insurance carrier. Our practice will ask you to assign all insurance company payments to our office to avoid any misunderstanding regarding payment for professional services. If you request instead that your insurance company pay you directly, then we will require full payment when services are rendered. You will be responsible for any portion of our bill which is denied or not paid by your insurance carrier. Your insurance coverage is a contract between you and your insurance carrier; however, we will assist you to maximize your insurance benefits. Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communications. We have instructed our staff to make every effort available to you to clarify and misunderstanding you have concerning your balance. We hope to possibly avoid any disagreement over payment for professional services. If you have any questions concerning our insurance policy or need assistance, please contact our practice immediately.

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Dr. Barinque, its successors and assigns, or any individual it may designate for services provided. I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due to services rendered and performed, I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to the Dr. Barinque, its successors and assigns and any individual it may designate for any balance not covered by insurance.

Signature of Patient or Parent of Minor _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Dr. Barinque for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature _____ Date _____