NEW PATIENT REGISTRATION

FIT FEET FOR LIFE **(813) 645-1993 (727) 824-5100**

Name: (First, Middle, Last, Suffix): _____ **Preferred Name:** _____

Address (Home/Local): _____
Street City State Zip Code

Telephone: (**)** _____- _____ ( ) _____- _____ ( ) _____- _____
cell home work/other

E-Mail: _____

□ Above as on Consent Form for (print your name) :

How did you hear about Fit Feet For Life? □ **Friend or** □ **Dr:**_____ (please provide name)
□ **Google** □ **Yahoo** □ **Sign** □ **Church Bulliten** □ **Yellow Pages/Other:** _____

Date of Birth: _____/_____/_____ **Gender:** Male / Female

Social Security Number: _____-_____-_____ **ID/Driver's License #**: _____

Preferred Language: English / Spanish / Other: _____ Translater needed? □ Yes / □ No

Address (Billing): _____
(Other than above) Street City State Zip Code

Emergency Contact: _____ ( ) _____- _____
(In case you are non-responsive or sent to hospital)

Preferred Location: □ Sun City Center □ St Petersburg □ Carillon □ Tampa □ Town N'Country

How will you plan to pay for your care or estimated responsibility today? □ Check □ Cash □ Credit Card □ Other

I am eligible for benefits using □ Medicare □ Advantage □ HMO □ PPO □ POS □ Worker's Comp □ Liability/Other

For identification and billing a valid Government Issued Photo ID and Insurance Information must be presented.

Primary Insurane Name: _____ Member ID#: _____

Secondary Insurance Name: _____ Member ID#: _____

Tertiary Insurance Name: _____ Member ID#: _____

___(initial) **CONSTENT TO TREATMENT:** I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results obtained.

___(initial) **COMPLICATIONS:** I understand that it is my responsibility to return to or report any changes in my condition to Fit Feet For Life.

___(initial) **PRIVACY NOTICE:** I acknowledge that I have reviewed or received the Privacy Notice Form from Fit Feet For Life.

___(initial)**AGREEMENT TO PAY FOR SERVICES**: For and in consideration of the care and treatment provided to the patient I promise to pay Fit Feet For Life, all charges for services rendered to or on behalf of the patient. Authorization from your insurance company does not guarantee payment. The undersigned and/or patient shall remain responsible for all charges co-payments and deductibles. Payment to Fit Feet For Life is due at time of services. I authorize the release of medical or other information needed to provide medical/services care or process claims. I request the payment of authorized benefits be made on my behalf. I assign the benefits and authorize payments for medical services from health insurance companies be made on my behalf to Fit Feet For Life, Dr. Bonnie Sanchez and/or her associates.

NOT ALL SERVICES AND PRODUCTS OFFERED BY FIT FEET FOR LIFE ARE COVERED BY ALL INSURANCE PLANS

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE AND IS THE PATIENT, GUARANTOR OR THE PATIENT'S REPRESENTATIVE DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Print Patient, Guarantor, P.O.A. or Representative Name: _____

Signature : _____ Date: _____

Review by: _____
(Staff Member)

6.27.2017