Patient Update Form **Date: __________**

Last Name			First Name		MI
Billing Address					
City:			State	Zipcode	
Home Phone			Cell Phone		
DOB	M / F		SSN		
Marital Status __ Single __ Married __ Separated __ Widowed					
Employer				Phone	
Insurance Company			Policy Number		
Policy Holder Name				DOB	
Secondary Insurance Company			Policy Number		
Email Address					
Primary Care Physician			Preferred Pharmacy		

Emergency Contact

Name	Relation	Phone

The above information is true to the best of my knowledge. I understand that I am financially responsible for my balance on any charges incurred. I authorize Family Footcare to release any information required to process my medical claims. In the event that I incur charges that are filed with my health insurance, I authorize my insurance benefits be paid directly to the physician.

______ **I HAVE READ AND AGREE TO THE ABOVE TERMS AND CONDITIONS**
INITIAL

Missed Appointment / Cancelation Policy

Every effort is made to see all patients in a timely manner. Once you make an appointment with a provider, that time is reserved exclusively for you. If it is necessary to cancel or reschedule your appointment, Family Footcare kindly asks that you do so at least 24 hours in advance so that we may offer this time to another patient in need of care. There will be a $50.00 cancellation fee for any appointment that is not canceled at least 24 hours in advance. We hope you understand that our time, like yours, is valuable.

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INITIAL

AS A SELF-PAY PATIENT

I attest that I have not presented any evidence of insurance coverage nor I do not have Medicaid. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time services are rendered, and I possess the means to tender payment today. I understand that I will be asked for a partial payment prior to being seen at the first visit. Any additional amounts due must be paid at the end of each visit. Any overpayment will be credited back at the end of each visit. If I have concerns about the amount of my charges incurred, I will ask a member of the medical staff **before** charges are incurred.

AS AN INSURED PATIENT

I understand that Family Footcare will assist me in submitting my medical claim to my insurance carrier. I hereby authorize payment directly to Family Footcare and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductible, coinsurance, and non-covered services. In the event that my health plan determines a service to be "not covered," I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed. I understand that statement balances are due at time of receipt.

Family Footcare reserves the right to withdraw further care if patient does not fulfill the obligation made under the above financial arrangements.

______ **I HAVE READ AND AGREE TO THE ABOVE TERMS AND CONDITIONS**
INITIAL

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CLIENT NAME

______________________________________ ____________________

CLIENT / GUARDIAN SIGNATURE DATE