

## **Insurance Information**

### *Patient's Primary Insurance*

Name of Company \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_  
Group # \_\_\_\_\_ Policy ID # \_\_\_\_\_

### *Patient's Secondary Insurance (If Applicable)*

Name of Company \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_  
Group # \_\_\_\_\_ Policy ID # \_\_\_\_\_

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### **Complete this section if someone else is the Primary Policy Holder**

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Responsible Party \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Phone # (\_\_\_\_) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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### **Workers Compensation Claims**

Referred By Doctor \_\_\_\_\_ Date of Accident \_\_\_\_\_  
Employer (at time of accident) \_\_\_\_\_ Employer's Phone # (\_\_\_\_) \_\_\_\_\_  
Claim # \_\_\_\_\_ Name of Insurance carrier: \_\_\_\_\_  
Adjuster's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

**Our office will file the insurance claims for medical and surgical charges. Self-Pay patients require payment on the date of service. Please remember, you are responsible for all fees, regardless of insurance coverage & all charges if a referral for HMO plans is not obtained prior to date of service.**

I authorize the release of any medical information to process insurance claims.

I authorize payment directly to Loveland Foot and Ankle Clinic, P.C. dba Advanced Foot and Ankle Care (AFAC) for medical and/or surgical benefits, if any, otherwise payable to me for the services as described, realizing that I am responsible to pay for non-covered services.

I have reviewed, understand and consent to the Financial Policies of Loveland Foot and Ankle Clinic, P.C. dba AFAC.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_