Family Foot & Ankle Center, PA
PATIENT INFORMATION

Patient's Name____
first *M.I.* *last*

SS# ____________________________ Date of Birth _____-_____-_____ Gender: Male Female

Home Address ____ Apt#____________

City__________________________ State ____________ Zip _________________________

Home # _______________________Work # ____________________ Cell # ________________________

E-mail ______________________________ Race_________ Ethnicity__________ Language _____________

Marital Status Married Single Divorced Widowed Other **Occupation**____________________________

Referring Doctor____

Your Pharmacy_______________________________**Phone**___________________________**Street**___________________

Responsible party name __________________________ ______________________ _______
Last *First* *M.I*

Responsible party Address ____

Primary Insurance Information

Policyholder Name _______________________________ Date of Birth_____-_____-______

Insurance Name____

Relationship to Policyholder: Self_______ Spouse_______ Child_______ Other_______

Employer Name ____

HIPAA Acknowledgement

I hereby acknowledge that I have been made aware that Family Foot & Ankle Center, PA (FFAC) has a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that FFAC has a privacy policy in effect and has made this policy available to me. I am entitled to an additional copy of the privacy policy if I desire. **Initials** __________

I authorize the release of any previous results or images in the event FFAC is in need of them to help with the diagnosis of my procedure today. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. Family Foot & Ankle Center, PA. will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances. **Initial** _________

I authorize FAMILY FOOT & ANKLE CENTER, PA (Dr. Douglas C. Smith or Dr. Patrick J. Dougherty, or whomever they designate) to administer treatment and to perform such general procedures as he (they) may deem necessary in the diagnosis and/or treatment of my foot condition. I further certify that to the best of my belief and knowledge the information provided on my personal health history is true and accurate. I also authorize the physician designated to release information acquired in the course of my examination and treatment.

X____ **Date**_____________________________

Patient signature or guardian for the minor patient

printed name____