Katz Medical Associates) 6600 34th Ave. N. St. Pete

Chart Number: _____ Date:_____

Patient_____
Last name First name Initial Name (desired to be called by)

Responsible Party (if a minor)_____

Street Address_____ City _____State_____ Zip Code_____

E-mail Address _____

Home Phone_____ Cell Phone_____

Birthdate _____ Age_____ Sex M F Single Married Widowed Separated Divorced

Social Security #_____ Emergency Contact_____ Phone_____

Primary Care Physician_____ Last Visit _____

Referred to our practice by _____ Heard about our practice by _____

Employer_____ Work Phone_____ Position/Occupation_____

Date of Injury _____ Date you were first treated _____ By Whom _____

PLEASE PROVIDE ALL YOUR INSURANCE CARDS TO BE COPIED

Name of Insured (if not patient): _____ Relationship to patient : _____ Employer: _____
Date of Birth (Insured) : _____ Occupation: _____ Work Phone: _____
Social Security Number (Insured) : _____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT AND RELEASE

I hereby give Katz Medical Associates and it's staff members permission to treat my foot and/or ankle disorders. I, the undersigned, have insurance coverage with _____and assign directly to Katz Medical all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Katz Medical for any services furnished me by that physician. 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. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature/Guardian Date

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT OF RECEIPT

I acknowledge have received a copy of Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understood the notice.

_____ _____
Patient Signature/Guardian Date