



INSURANCE INFORMATION

Primary Insurance Company Name: _____ ID/MEMBER # _____
Group Name: _____ Group # _____
Effective Date: _____ Expiration Date: _____
Patient's Relationship to Policy holder: _____ Policy Holder Name: _____
Secondary Insurance Company Name: _____ ID/MEMBER # _____
Group Name: _____ Group # _____
Effective Date: _____ Expiration Date: _____
Patient's Relationship to Policy holder: _____ Policy Holder Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Address: _____
Home Phone () _____ Work Phone () _____ Ext: _____

EXPLANATION OF PAYMENT POLICY & INSURANCE FILING PROCEDURES

I hereby authorize ELITE FOOT & ANKLE, PA to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient named above and the facility.
I authorize my insurance carriers to pay benefits directly to ELITE FOOT & ANKLE, PA for any unpaid services filed on my behalf by ELITE FOOT & ANKLE, PA.
I understand that I AM RESPONSIBLE for payment to ELITE FOOT & ANKLE, PA for charges regarding the above patient regardless of my insurance coverage. I also understand that ELITE FOOT & ANKLE, PA is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

Patient / Guardian Signature: _____ Date: _____

ELITE FOOT & ANKLE, PA
4222 TRINITY MILLS ROAD
SUITE 112
DALLAS, TEXAS 75287-7660
Office: 214-710-1028
Fax: 214-710-1029