FUTCH | PODIATRY

145 Hilden Road | Suite 103 | Ponte Vedra, Florida 32081 | 904-615-1853 | 904-615-1873 (fax)

PLEASE PRINT INFORMATION

	Primary	**Secondary**
Name of Insurance Company	____________________________	____________________________
Policy Number	____________________________	____________________________
Group Name	____________________________	____________________________
Group Number	____________________________	____________________________
Name of Insured	____________________________	____________________________
Insured Date of Birth	____________________________	____________________________
Insured Social Security Number	____________________________	____________________________
Employer of Insured	____________________________	____________________________

PLEASE READ CAREFULLY:

Futch Podiatry will apply for patient insurance benefits. The patient is responsible for ALL fees, regardless of Insurance Coverage. All charges are due at time of service unless other arrangements have been made in advance.

I understand that I am responsible for any amount NOT covered by insurance. I hereby authorize payment directly to Futch Podiatry all insurance benefits not to exceed the regular charges. I hereby authorize Futch Podiatry to release the information needed to any physician and/or third party responsible for payment of such services.

____________________________ ______________ ____________________________
(Patient's signature or legal guardian) (Date) (Staff's signature)