The Foot and Ankle Wellness Center of Western Pennsylvania

PATIENT INFORMATION

Patient's Last Name:..... First Name:..... M.I.:..... Age: .....

Sex:..... Birth date: ...../...../..... Marital Status: ☐ S ☐ M ☐ W ☐ D

Social Security Number: ..... - ..... - .....

Home Address:.....

City: ..... State: .....

Zip Code: ..... E-Mail Address: .....

Home Phone Number: ..... - ..... - ..... Cellular Phone Number: ..... - ..... - .....

Who is financially responsible for billing

Name of responsable party: .....

Date Of Birth: ...../...../.....

Relationship to patient: .....

OCCUPATION

Patient's Occupation:..... Patient Employer:.....

Employer's Address: .....

City: ..... State: .....

Zip Code: ..... Employer Phone Number: ..... -..... - ..... Ext:.....

OTHER INFORMATION

Primary Care Physician Name and Address: .....

.....

How were you referred to our office? ☐ Primary Care Physician ☐ Another Physician (Name :) .....

☐ Yellow Pages ☐ Friend or Relative ☐ Health Insurance Company ☐ Other: .....

In Case of emergency notify:..... Relationship: .....

Phone:..... -..... -..... Cellular Phone Number: ..... -..... -.....

Ford City Location
313 Ford Street
Ford City, PA 16226
P: (724) 763-4080
F: (724) 763-4083

Butler Location
100 Evans Road
Butler, PA 16001
P: (724) 841-0188
F: (724) 841-0189
Toll Free: (844)-FOOTDOC (366-8375)

Monaca Location
3578 Brodhead Road
Monaca, PA 15061
P: (724) 775-6168
F: (724) 775-2633

Grove City Location
675 N. Broad Street Ext, Suite 2
Grove City, PA 16127
P: (724) 450-1144
F: (724) 450-1140

www.fawcpa.com

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INSURANCE INFORMATION

Primary Company: .....
Insurance Co. Address: .....
.....
Policy Number: .....
Group Number: .....
Subscriber Name: .....
Subscriber Employer: .....
Guarantor's Name: .....

Secondary Company: .....
Insurance Co. Address: .....
.....
Policy Number: .....
Group Number: .....
Subscriber Name: .....
Subscriber Employer: .....
Guarantor's Name: .....

ACCIDENT INFORMATION

Accident Related To: ☐ Work ☐ Auto ☐ Other:
Date of Injury: ..... / ..... / ..... Location of Injury: .....
Responsible Party: .....
Responsible Party's Address: .....
City: ..... State: ..... Zip Code: .....
Responsible Party Phone Number: ..... - ..... - ..... Ext: .....
Brief Description of the Injury: .....
.....

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY FOR YOUR FILE

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ASSIGNMENT OF BENEFITS

THE FOLLOWING IS REQUIRED BY LAW:
PLEASE READ CAREFULLY AND SIGN

I request and authorize **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo,** to release any information to the Health Care Financing Administration, Medical Assistance and my insurance company required to process my healthcare claim for services rendered by T**he Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo.** I understand my signature authorizes **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo** & Staff to examine and treat me including x-rays; I also understand payment for services or items could be for federal and/or state laws.

I hereby request payment be made directly to **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo,** by authorizing Medicare, Medical Assistance, and/or all other insurance companies for any and all services rendered to me through **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo.**

I understand I am personally responsible for all charges which Medicare, Medical Assistance and/or any other insurance company may or may not pay, including but not limited to co-insurance, co- payments, deductibles and non-covered services. I agree to make payment in full within 30 days of receipt of billing. Aged account balances may forward for collection with additional fees being incurred. Finally, I understand and agree this authorization will remain in effect until such time I request, in writing, termination of this authorization.

Patient Name: (please print) .....

Signature of Responsible Party: ..... Date: / /

Witness: ..... Date: / /

:: **NOTICE:** If you received podiatric care by another physician within the past 61 days, **MEDICARE** may not pay for these services and you will be responsible. ::

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