Welcome to our practice

Central Minnesota Foot and Ankle Associates

Dr. Greg Rouw * Dr. Karen Rouw

#1 PATIENT INFORMATION

Patient Name _____

Address_____

City_____State_____Zip_____

Sex __M__F Age_____ Birthdate_____/_____/_____

__Married__Widowed__Single__Minor

__Separated__Divorced__Partnered for____years

Occupation_____

Patient's employer/School_____

Spouses Name _____

Spouses Birth date_____/____/_____

Spouses Employer_____

Were you referred to our office?

__No __Yes, by_____

How did you find out about us?

___Phone Book ___ Radio Ad ___Sign on Building

___Internet____Friend/Patient_____Other_____

#3 CONTACT INFO

Home Phone (_____) _____
Work Phone (_____) _____
Cell Phone (_____) _____
e-mail address _____
IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Home Phone (_____) _____
Work Phone (_____) _____

#2 INSURANCE

Who is responsible for this account?_____
Relationship to Insured_____
Employer of Insured_____
Insurance Co._____
Is patient covered by other insurance? __Yes__No
Subscriber's Name_____
Birth date ___/___/_____
Relationship to Patient _____
Insurance Co. _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Central Minnesota Foot and Ankle Associates all insurance 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 Central Minnesota Foot and Ankle Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

_____
Responsible Party Signature

_____
Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Central Minnesota Foot and Ankle Associates for any services furnished to me by their physicians and staff. 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 authorize release of medical information necessary to process/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 suppliers agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co insurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature Date

REQUIRED INFORMATION

What is your primary preferred language? ____English ____Other: Specify _____

Do you classify your Ethnicity as: ____Hispanic or Latino, ____Non Hispanic or Latino, ____Other

Do you classify your race as: ___American Indian or Alaska Native ___Asian ___Black or African American

___Native Hawaiian or other Pacific Islander ___White ____Other