





### 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**