BARRETT PARKWAY FOOT AND LEG SPECIALISTS. P.C.
MICHAEL W DIXON DPM, FACFAS, FACFAOM, CWS

PHONE 770-422-0280 FAX 770-426-5388

Patient Name	First	Middle	Last	Birthdate	Age	Gender	Social Security Number
							- -

Home Address	City	State	Zip

Employer:	Occupation:	Marital Status:

Home Phone#	Cell Phone#	Work Phone #	Email address

Spouse (Parent / Guardian)	Spouse, Parent Work Phone#	Pharmacy Name and Phone#

Primary Insurance Name and Policy Holder Name (Parent/ Spouse)

Secondary Insurance Name and Policy Holder Name (Parent/ Spouse)

Patient relationship to Insured:

I hereby name as assignee and also instruct and direct my insurance company and/ or government benefits payor to pay by check(s) made out to the assignee: **Barrett Parkway Foot and Leg Specialists PC**

This is a direct assignment of my rights and benefits under this policy. In order that the assignee may determine my benefits and subsequently submit a claim for payment for services covered under my policy or government benefits program, I give the assignee, my insurance company, the Health Care Finance Administration and their agent(s) and/or any other holder of information about me, the authorization to release and/or exchange medical, billing, and collection information for purposes of obtaining payment for the services rendered.

Sign and Date:

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I authorize the Doctor(s), Associate Doctor(s), and staff of the medical practice named on this form, to treat the patient on this form and agree to pay fees and charges for such treatment. I acknowledge that I am responsible for the payment of services from me or my insurance or payor and that understanding of the processing of claims is my responsibility. If any account balance is not paid in full within 30 days from the date of service, the account will be subject to monthly interest or service charge and that any form of payment used in the past (credit cards and other with a convenience fee for any non in-person transaction) may be used to bring account balances current. This does not include payments made directly to me from an insurance company or other payor. These funds are due immediately and if not paid promptly will constitute revoking of the 30 day period and will result in a collections process. Some services require payment at the time of service. Bad checks (including fees) and other finance charges are my responsibility. No shows for an appointment are my responsibility and I will be charged for the no show if cancellation of appointment is not done at least 24 hours prior to my appointment. Any unpaid balance will be turned over for collections after 30 days or sooner if there is a missed appointment or no contact with our office by the patient. If the balance on any account is not paid within 30 days, interest and account fees will be charged. If any account is turned over to collections, attorneys fees and interest including principle and interest amounts will be charged. This is subject to change at any time without notice.

Sign and Date (parent must also sign if patient is under 18 years old):

Sign and Date (parent or other legally responsible person):