A. Michael Marasco, DPM, FACFAS

Medicine and Surgery of the Foot and Ankle - Podiatric Sports Medicine

Person Responsible For This Account if Other Than Self _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

INSURANCE INFORMATION

Name of Insurance Carrier _____

Please attach your insurance card (s) and a photo ID to this form.

I authorize my insurance benefits to be paid directly to the physician and I understand I am financially responsible for any and all co-payments, deductibles and non-covered services. I understand that some services may be denied by certain insurance plans due to medically necessity and I agree to be financially responsible for these services. Payments are due upon receipt of services and or statement. Accounts not paid in 30 days will be considered Past Due and subject to rebilling fees. Accounts 90 Days Past Due are considered Delinquent. If it becomes necessary to employ a collection agency, service or attorney to enforce payment you will be responsible for the costs and fees charged for such services. I authorize the physician to release any information necessary to process claims for insurance benefits. I understand that honest and complete answers in questions stated are important to the provisions of my medical care. I have been informed that if I am uncertain about any questions on this Patient Information Sheet or Health Questionnaire I should ask the doctor or a member of the office staff for assistance.

_____ _____

Signature of Patient or Legally Responsible Adult Date