

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: - -

If the patient is a **minor**, please give name of parent or guardian, who is financially responsible for billing

Name of spouse/Parent: Birth Date: / /
Spouse's/Parent's Employer: Number: - - Ext:
Employer's Address:
City: State:
Zip Code: Employer Phone Number: - - Ext:

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: - -

Butler Location

Monaca Location

Grove City Location



INSURANCE INFORMATION

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

The Foot and Ankle Wellness Center
of Western Pennsylvania

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 **The 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. **::**

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