Bergen Foot Ankle Group
Patient Registration Form

Patient Information		
Patient Name (Last, First):		
Date of Birth: / /	SSN: - -	Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W
Address:		
City:	State:	Zip:
Cell Phone:	Home Phone:	
Employment:	Email:	
Emergency Contact:	Emergency Contact Phone:	

Insurance Information	
Primary Insurance:	
Policy #:	Group #:
Secondary Insurance:	
Policy #:	Group #:

Responsible Party (if patient is not financially responsible for account)		
Responsible Party Name (Last, First):		
Date of Birth: / /	SSN: - -	Gender: ☐ M ☐ F
Address:		
City:	State:	Zip:
Cell Phone:	Relation to Patient: ☐ Self ☐ Child ☐ Spouse ☐ Other	

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____ Doctor Referral (who?)_____

Insurance Company_____ Facebook_____ Other_____

Payment is required at the time that the services are rendered unless you are a member of a participating insurance plan. I authorize the release of information concerning my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluation and administering claims for insruancebenefits. If the provider bills my health insurance company on my behalf, I authorize payment to be paid directly to the provider. Any applicable co-payment, co-insurance, and/or deductible will be collected at time of service. I am ultimately responsible for understanding my insurance coverage and whether my insurance coverage is participating with the provider and contracted to perform services at a predeterminedrate. I understand that my insurance company will make the final determination as to what services are covered. I understand the terms of payment and I have been given the opportunity to read Bergen Foot & Ankle Group's financial policy. I understand and accept that I am ultimately responsible for payment of services rendered by the provider if such services are not paid for by my insurance. I understand that a late charge of 1.5% per month may be applied to any unpaid patient balance that is not paid within 30 days from receipt of a bill.

In the event that if DME or customized orthotics is recommended as part of the treatment, patient is informed on the price and Non-Refundable Policy on the product, and agrees to the Non-Refundable Policy of the product. If patient disagrees, patient have the right to choose to not purchase DME or customized orthotics. However, once patient purchased the DME or customized orthotics, there will be no refund available.

X:_____Date:_____

Signature of Patient or Guarantor