Marcus Duval, D.P.M.
LAKEVILLE FOOT & ANKLE

PATIENT REGISTRATION

Last Name First MI Sex

Address Apt #

City State Zip

Birth Date Age ( ) Cell Phone #

Email

POLICY HOLDER/RESPONSIBLE PARTY
(If other than patient: parent/guardian or spouse)

Last Name First

Address

City State Zip

Birth Date ( ) Cell Phone #

Email

Is what you are being seen for **WORK RELATED?** YES _____ NO________ **AUTO RELATED?** Yes _______ NO ______

Whom may we thank for referring you? Referring Doctor___________________Clinic _____________________________
Insurance Provider Book________Yellow Pages ______Website_____________Other (i.e. friend) ____________________

- -

Consent to Treat: I hereby authorize Marcus Duval, D.P.M., of the Lakeville Foot Clinic to administer such treatment as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

Financial Responsibility: I agree that I am financially responsible for all charges for services rendered. I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree it is my responsibility to obtain prior approval required by my insurance company and to take all other steps to qualify for insurance coverage.

Assignment of Benefits: I hereby assign to Marcus Duval, D.P.M., all insurance coverage or other benefits available under any government program, and insurance policy or plan, and any other benefits program, and I direct that all benefits be paid directly to Marcus Duval, D.P.M.

Release of Information: I authorize Marcus Duval, D.P.M. to release all medical information, via facsimile or mail, including any information relating to treatment for mental health, alcohol or drug abuse, and or HIV/AIDS related information, required by my insurance company or Worker's Compensation carrier or designee to file for medical benefits. Additionally, Marcus Duval, D.P.M. may release information, via facsimile or mail, to any hospital or physician I may be referred from, or referred to, by Marcus Duval, D.P.M.

Patient Signature Date Parent/Guardian Signature Date

Medicare Statement (if applicable): I request that payment of authorized Medicare benefits be made on my behalf to Marcus Duval, D.P.M., for any services furnished to me. I authorize any holder of medical information about me to release to _______________________________ (name of Medicare insurance carrier) any information needed to determine these benefits or the benefits payable for related services.

Patient Signature Date Parent/Guardian Signature Date

Witness Date