

Patient's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M / F  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone (Hm): \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Spouse's Name: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Physician First/Last Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Whom May We Thank for Referring You to Our Office?: \_\_\_\_\_ Phone # \_\_\_\_\_

#### PRIMARY MEDICAL INSURANCE

Address: \_\_\_\_\_ Phone # \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
Insured's Social Security Number: \_\_\_\_\_ Patient ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Phone # \_\_\_\_\_

#### SECONDARY MEDICAL INSURANCE

Address: \_\_\_\_\_ Phone # \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
Insured's Social Security Number: \_\_\_\_\_ Patient ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Phone # \_\_\_\_\_

#### ASSIGNMENT OF BENEFITS

Your Signature is necessary for us to process any insurance claim to insure payment of services rendered on your behalf. I request that payment of authorized insurance or Medicare benefits be made to me or on my behalf to Eric Lullove, D.P.M. for any services furnished by that provider. for any services furnished by that provider. I authorize any medical information about me be released to the insurance carrier or to Health Care Financing Administration and its Agents as needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

#### BILLING PROCEDURES

I understand that I am ultimately responsible for payments on my account. A \$25.00 Non-Sufficient-Funds charge will be applied for a returned check. Eric Lullove, D.P.M. has the right to request future services be paid in cash. Unpaid balances over 120 days may be referred to an outside collections agency. If you have no insurance, payment is required at time of service. In divorce or custody situations, the person with full-time legal custody of the minor patient will be responsible for payment. If custody is shared, the parent with whom the child resides for school purposes will be responsible for payment. If another parent has insurance responsibilities, written authorization is needed, including legal signature and billing information.

I Have Read and Understand the Eric Lullove, D.P.M. Account Billing Procedures.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### HMO REFERRALS

I understand that in order for my insurance carrier to consider payment for this visit, a referral is required from my Primary Care Physician. I am seeking care from Eric Lullove D.P.M., knowing that a referral has not been received from my Physician at the time of visit. I therefore understand that I may even be financially responsible for part or all of the charges related to this or future visits, including Lab, X-Rays, Treatments, and other Services. I understand with a Physician referral my insurance provider may not cover some provided services. I agree to pay for these services if they are not covered, either today or on future visits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_