Missouri Foot & Ankle Clinic, PC

Dr. Daniel Hanon, DPM & Dr. Ann Hanon, DPM

Blue Springs	Encompass Medical Group
1136 SW 40 Hwy.	1741 NE Douglas St.
Blue Springs, Mo 64015	Lee's Summit, Mo 64086

Date:_____

Name:_____ DOB:_____
First M.I. Last

Telephone: (H)_____ (W)_____ (C)_____

Address:_____

City:_____State:_____ Zip:_____

SS#_____ Race:_____

Ethnicity (circle which applies) (1)Not Hispanic or Latino (2)Hispanic or Latino

Sex: Male Female Marital Status: S M W D

Employer: _____

Are you a Student? Yes No Full-Time Part-Time N/A

Family Physician:_____

Date last seen:_____ Referred by:_____

Have you been seen by Dr. Hanon before? Yes No

If Yes, Where? (Office, Hospital, Other)

Approximate date of last visit/exam:_____

Do you have medical insurance?: YES NO

Name and DOB of policy holder (if different from patient):_____

Is your visit due to an accident? Yes No

Is this Workers Compensation? Yes No

Emergency Contact Information:

Name:_____

Telephone #_____ Relationship to Patient:_____

THE FOLLOWING IS REQUIRED BY LAW:
PLEASE READ AND CAREFULLY SIGN

I request and authorize Missouri Foot & Ankle Clinics PC, Dr. Daniel Hanon & Dr. Ann Hanon 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 Foot & Ankle Clinics PC, Dr. Daniel Hanon & Dr. Ann Hanon. I understand that my signature authorizes Foot & Ankle Clinics PC, Dr. Daniel Hanon & Dr. Ann Hanon & 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 Foot & Ankle Clinics PC, Dr. Daniel Hanon & Dr. Ann Hanon by authorizing Medicare, Medical Assistance, and/or other insurance companies for any and all services rendered to me through Foot & Ankle Clinics PC, Dr. Daniel Hanon & Dr. Ann Hanon.

I understand I am personally responsible for all charges which Medicare, Medical Assistance and/or any other insurance company 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 to collection with additional fees od at least $10.00 being incurred. Finally, I understand nd 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 signature: _____ Date:_____

*** IF YOU HAVE RECEIVED PODIATRIC CARE BY ANOTHER PHYSICIAN WITHIN THE PAST 61 DAYS **MEDICARE** MAY NOT PAY FOR THESE SERVICES AND YOU WILL BE RESPONSIBLE***