



Dr. James J. Longobardi

Diplomate A.B.P.O.

Podiatric Medicine and Surgery of the Foot
A Gentle Approach to Foot Care

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please Print. All information will be confidential.

Date _____ Patient Name _____

FIRST MI LAST

SSN _____ £ Male £ Female Birthdate _____ Home phone _____

Address _____ Apt _____ City _____ State _____ Zip _____

Check appropriate box: £Minor £Single £ Married £Divorced £ Widowed £ Separated

Patient's or parent's employer _____ Work phone _____

*Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____ Relationship _____

Primary Physician _____ Phone _____

Address _____

Responsible Party (This is not your insurance)

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birthdate _____ Social Security # _____

Insurance Information

PRIMARY

Insurance company _____

Name of insured _____ Relationship to patient _____

SECONDARY

Insurance company _____

Name of insured _____ Relationship to patient _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____
Signature of patient or parent if minor

Date

James J. Longobardi, D.P.M.

Our Financial Policy

Dear patient:

Thank you for choosing Absolute Foot Care as your foot care provider. The following is our financial policy. Our main concern is that you receive optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our financial policies please do not hesitate to ask our billing office. You may do so by calling 619-477-1636, (Mon thru Fri, (9-5).

We ask that all patients read and sign our **Financial Policy** as well as complete our Patient information form prior to seeing the doctor.

Payment for services is due at the time of service. We accept cash, checks, and credit cards.

In special instances we may accept assignment of insurance benefits (Medicare, Med-I-Cal, Champus, and Commercial Insurance), however you must understand that:

1. Your insurance policy is a contract between you, your employer and your insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.
5. If the insurance company does not pay your balance within 30 days, we ask that you contact the carrier to help expedite the payment.
6. If the insurance company does not pay the balance within 45 days, we require you to pay the balance due with cash or check.
7. Returned checks are subject to additional collection fees. A \$10.00 rebilling charge will be added to all unpaid balances past 30 days.

Please call if you have to reschedule an appointment. This is a nice courtesy to someone who may need to be seen in your place.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing Absolute Foot Care as your foot care provider. We appreciate your trust in letting us provide care for your foot health needs.

Patient Signature

Date