Robert W. Sullivan, DPM, PC
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Board Certified, American Board of Podiatric Surgery *Fellow American College of Foot and Ankle Surgery*

PATIENT INSURANCE INFORMATION- FORM D

Name: _____ Date of Birth: _____

Home phone: ( ) _____ Emergency Contact: _____ Phone: _____

Work phone: ( ) _____ Ext: _____ Cell phone: ( ) _____

Address:_____City:_____State:_____Zip:_____

E-mail address: _____

Social Security: _____ Sex: ___ M ___ F Marital Status: _____

Referral Source: ___ Advertisement ___ Family/Friend ___ Insurance: ___ Phone Book ___ Other: _____

Referring MD: _____ Date of Last Visit: _____ Treating MD: _____

INSURANCE INFORMATION

Primary: _____Policy Holder: _____Policy Holder DOB:_____

ID#/Member#: _____ Group #: _____

Secondary: _____Policy Holder: _____Policy Holder DOB:_____

ID#/Member#: _____ Group #: _____

Patient's relation to policy holder: _____

Please READ and INITIAL A through C, then sign and date below:

A. Assignment and Release:
I, the undersigned, have insurance coverage with the above mentioned insurance and assign to Dr. Sullivan all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions. **INITIAL_____**

B. Acknowledgement of Privacy Practices:
I acknowledge that I was provided a copy of the Privacy Practices and that I have read and understand the Notice. **INITIAL_____**

C. Financial Agreement:
I acknowledge that I was provided a copy of the Financial Agreement. I have read and understand the policy and agree to comply with the conditions as presented. **INITIAL_____**

Signature: _____ Date: _____