Fred TOENGES
Shoes and Pedorthics.

Billing ID# .

****ALL FIELDS ARE REQUIRED FOR BILLING INCLUDING SOCIAL SECURITY NUMBERS FOR ALL FIELDS!**

Patient Information

Patient_____Date of Birth_____S.S.#_____

Address_____City_____State_____

Zip_____Home Phone_____Alt. Phone_____

Gender: Male Female Referring Physician_____Primary Physician_____

If patient is a child or dependant, complete this section

Name of Responsible Party_____

Relationship to Patient_____Date of Birth_____S.S.#_____

Address_____City_____State_____

Zip_____Home Phone_____Alt. Phone_____

***Medicare recipients**: Are you currently under a Part A stay at any facility? ☐ Yes ☐ No

If YES, what is the name, address & phone number?_____

_____

Primary Insurance

Insurance:_____

Insurance ID#:_____Group #:_____

Policy Holder:_____Relationship to Patient:_____

Policy Holders Date of Birth:_____Policy Holders S.S.#_____

Address (**only if different**):_____

City:_____State:_____Zip:_____

Secondary Insurance

Insurance:_____

Insurance ID#:_____Group #:_____

Policy Holder:_____Relationship to Patient:_____

Policy Holders Date of Birth:_____Policy Holders S.S.#_____

Address (**only if different**):_____

City:_____State:_____Zip:_____

I have read and understand the Fred Toenges Shoes & Pedorthics Payment/Return Policy. I understand that Fred Toenges Shoes & Pedorthics is acting solely as an agent for filing insurance benefits assigned to it. However, Fred Toenges Shoes & Pedorthics assumes no responsibility for guaranteeing payment of covered charges. **I understand that I am fully responsible for all deductibles, coinsurance and disallowables. I recognize and affirm my obligation to Fred Toenges Shoes & Pedorthics the total of all charges incurred and this obligation is in no way dependent upon reimbursement under any medical insurance plan. Any arrangement whereby payments are made directly to Fred Toenges Shoes & Pedorthics through any insurance plan shall not affect my obligation to pay the remaining balance.** I authorize the release of any medication information necessary to process this claim through Fred Toenges Shoes & Pedorthics.

_____ _____

Signature of Patient or Responsible Party Date