FAMILY
Foot Care

__ " I hereby authorize my insurance company to remit payment to Family Foot Care, for services rendered. I also am aware that I am financially responsible for non-covered services, copayments, deductible and/or coinsurance balances"

___" I give authorization for Family Foot Care to release any information needed to process my claim"

__"I authorize Family Foot Care to obtain my medication history"

__CANCELLATION/"NO SHOW" APPOINTMENT POLICY
There will be a **$20** charge for all missed appointments. Kindly call 24 hours in advance to cancel or reschedule your appointment. Thank You

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Patient's name (please print)

Patient or Guarantor Signature (responsible party) Date

(IF patient is a MINOR, under 18 years of age, please give name of parent or guardian, who is financially responsible for billing)

Name of
Parent/Guardian:_____

Address:_____

Home/Cell Phone Number:_____
Date of Birth:_____
Social Security Number:_____
Employer Name/Address/Phone:_____

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