

MISSOURI FOOT & ANKLE CLINICS, PC

Dr. Daniel Hanon & Dr. Ann Hanon

1136 W 40 Hwy
Blue Springs, MO 64015

DATE: _____

Patient Information

Name: _____

First Middle Initial Last

Address: _____ City: _____

State: _____ Zip: _____

Telephone # (H)() _____ (W)() _____ (C)() _____

Social Security: _____ Employer: _____

D.O.B. _____ Age: _____ Sex: M F Marital Status: S M W D

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

Family Physician: _____ **Last Date Seen:** _____

Referred By: _____

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

If yes, where? (office/ hospital other) _____

Approximate date of last exam: _____

Insurance Information

Do you have medical insurance? Yes No

Primary coverage: _____

Agreement ID#: _____ Group #: _____

Person whose name the policy is under? _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Tel. # _____ May we contact you at work? Yes No

Complete this section if the patient is not the subscriber or the person responsible for payment is not the patient.

Subscriber Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Tel #: _____

Sex: M F Relationship to patient: _____

Employer: _____ State: _____ Zip: _____

Tel. # _____

Secondary Insurance Information

Subscriber Name: _____ DOB: _____

Agreement # _____ Group # _____

Secondary insurance carrier: _____

Is medical assistance your secondary? Yes No

Is your visit related to an accident? YES NO

Is this Workers Compensation? YES NO

Date of Injury: _____ Employer: _____

Emergency Contact Information:

Person to contact in case of an emergency:

Name: _____ Telephone # _____

Relationship to Patient: _____

**THE FOLLOWING IS REQUIRED BY LAW:
PLEASE READ CAREFULLY AND 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 **Missouri Foot & Ankle Clinics PC, Dr. Daniel Hanon & Dr. Ann Hanon**. I understand my signature authorizes **Missouri 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 **Missouri Foot & Ankle Clinics PC, Dr. Daniel Hanon**, by authorizing Medicare, Medical Assistance, and/or all other insurance companies for any and all services rendered to me through **Missouri 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 or 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 for collection with additional fee of at least \$10.00 being incurred. Finally, I understand and 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: _____ Date: _____

If you received podiatric care by another physician within the past 61 days, **MEDICARE** may not pay for these services and you will be responsible.