

Printed patient name

MOBILE PODIATRY REGISTRATION FORM

All Fields are REQUIRED. Leave no blanks – use "N/A" or "None," as applicable.

SECTION 1: FACILITY INFORMATION

Address: City: State: Zip: Reason (s) for referral	Address: City: State: Zip: Reason (s) for referral	Name:	Phone:	Fa	nx:
Reason (s) for referral Facility Contact Name/title: SECTION 2: PATIENT INFORMATION Mr	Reason (s) for referral Facility Contact Name/title: MI: Last:	Address:	City:	State:	Zip:
SECTION 2: PATIENT INFORMATION Mr	SECTION 2: PATIENT INFORMATION	Reason (s) for referral			
Mr Ms Mr First: MI: Last: DOB: Height: Weight: Shoe size: Diabetic: Yes No Primary Phone: Type: Cell Home Email: Responsible Party (if other than patient) Address: Phone Number: Relationship to Patient: SECTION 3: INSURANCE INFORMATION (Attach copy of each insurance card) Primary Insurance: Policy Number: SECTION 3: INSURANCE INFORMATION (Attach copy of each insurance card) Primary Insurance: Policy Number: SECTION 4: PATIENT PAST MEDICAL HISTORY SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: Phone: Previous Podiatrist: Last Seen: Phone: SECTION 7: PHARMACY Name: Phone: SECTION 7: PHARMACY Name: Phone: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLASE READ CAREFULLY AND SIGN PRIOW: and contained provious in mountain price in one obtained provious production of the contained provious in mountain provious production of the contained provious provious production of the contained provious provious production of the contained provious production of the contained provious provious production of the contained provious provious production of the contained provious in mountained provious in mountained provious in mountained provious in mountained provious provious provious production of the contained provious and manifold provious with provious provious provious provious provious provious provious provious provious provio	Mr Ms Mr First: MI: Last: DDB: Height: Weight: Shoe size: Diabetic: Yes No Primary Phone: Type: Cell Home Email: Responsible Party (if other than patient) Name: Address: Phone Number: Relationship to Patient: SECTION 3: INSURANCE INFORMATION (Attach copy of each insurance card) Primary Insurance: Policy Number: SECTION 3: INSURANCE INFORMATION (Attach copy of each insurance card) Primary Insurance: Policy Number: SECTION 4: PATIENT PAST MEDICAL HISTORY SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: / Phone: Previous Podiatrist: Last Seen: / Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEMENT & AGREEMENT PLEAS READ CAREFULLY AND HIGH BELOW: FUNDAL ACKNOWLEGDEM	Facility Contact Name/title:			
DOB: Height: Weight: Shoe size: Diabetic: Yes No	DOB: Height: Weight: Shoe size: Diabetic: Yes No	SECTION 2: PATIENT INFORMAT	TION		
DOB: Height: Weight: Shoe size: Diabetic: Yes No	DOB: Height: Weight: Shoe size: Diabetic: Yes No	□ Mr □ Ms □ Mrs First:	MI: I	ast:	
Primary Phone: Type: Cell Home Email: Responsible Party (if other than patient) Name: Relationship to Patient: Policy Number: SECTION 3: INSURANCE_INFORMATION (Attach copy of each insurance card) Primary Insurance: Policy Number: SECTION 4: PATIENT PAST MEDICAL HISTORY SECTION 5: PATIENT MEDICAL HISTORY SECTION 5: PATIENT MEDICAL HISTORY SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: Phone: Previous Podiatrist: Last Seen: Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Responsible Party/Guarantor's Signature (if applicable): Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT SECTI	Primary Phone: Type: Cell	DOB: Height:	Weight: Shoe size:	Diabe	etic: Yes No
Responsible Party (if other than patient) Name:	Responsible Party (if other than patient) Name:	Primary Phone:	Type: Cell Home Email:		
Primary Insurance: Policy Number: Secondary Insurance: Policy Number: Policy Numb	Primary Insurance: Policy Number: Po	Responsible Party (if other than pation	enf)		
Primary Insurance: Policy Number: Secondary Insurance: Policy Number: Policy Numb	Primary Insurance: Policy Number: Po	Name:	Address:		
Primary Insurance: Policy Number: Secondary Insurance: Policy Number: Policy Number: Secondary Insurance: Policy Number: Policy Number: Secondary Insurance: Policy Number: Secondary Insurance: Policy Number: Secondary Insurance Secondary Insuranc	Primary Insurance: Policy Number: Secondary Insurance: Policy Number: Policy Number: Secondary Insurance: Policy Number: Policy Number: Secondary Insurance: Policy Number: Secondary Insurance: Policy Number: Secondary Insurance	Phone Number:	Relationship to Patient:		
Primary Insurance: SECTION 4: PATIENT PAST MEDICAL HISTORY SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: / Phone: Previous Podiatrist: Last seen: / Phone: SECTION 7: PHARMACY Name: Previous Podiatrist: Last Seen: / Phone: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Responsible Party/Guarantor's Signature (if applicable): Date: Manage: Phone: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Responsible Party/Guarantor's Signature (if applicable): Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Consense of the second of t	Primary Insurance: SECTION 4: PATIENT PAST MEDICAL HISTORY SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: / Phone: Previous Podiatrist: Last seen: / Phone: SECTION 7: PHARMACY Name: Previous Podiatrist: Last Seen: / Phone: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Responsible Party/Guarantor's Signature (if applicable): Date: Manage: Phone: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Responsible Party/Guarantor's Signature (if applicable): Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Consense of the second of t	SECTION 3: INSURANCE_INFORM	MATION (Attach copy of each insurance card)		
SECTION 4: PATIENT MEDICAL HISTORY SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: / Phone: Previous Podiatrist: Last Seen: / Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: FUND CONTROL OF COMMENT OF COMM	SECTION 4: PATIENT MEDICAL HISTORY SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: / Phone: Previous Podiatrist: Last Seen: / Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: FUND CONTROL OF COMMENT OF COMM	Primary Insurance:	Policy Nun		
SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: / Phone: Previous Podiatrist: Last seen: / Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: **Understanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have yoluntarily entered into a financial agreement with STRIDE FOOT GLE CENTER, LLC. a professional Lamined Liability Company, for Pediatric Medical and Surgeal services. **END OFFICE PROPERS AND STRING FOR A PLOTE CENTER, LLC. a professional Lamined Liability Company, for Pediatric Medical and Surgeal services and services the day of my visit. *END OFFICE PROPERS AND STRING FOR A PLOTE CENTER, LLC. a professional Lamined Liability Company, for Pediatric Medical and Surgeal services. This amount can be paid in cast discussed and the control of the professional Lamined Liability Company, for Pediatric Medical and Surgeal services the day of my visit. *END OFFICE PROPERS AND STRING FOR A PLANC CENTER, LLC. a professional Lamined Liability Company, for Pediatric Medical and Stripe for a presponsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. *END OFFICE PROPERS AND STRING FOR A MARC CENTER, LLC will file my Insurance as a Courtey. Any Co-pay, Deductible venual services the day of my visit. *END OFFICE PROPERS AND STRING FOR A MARC CENTER, LLC will file my Insurance as a Courtey. Any Co-pay, Deductible venual services the day of my visit. *END OFFICE PROPERS AND STRING FOR A MARC CENTER, LLC will file my Insurance as a Courtey. Any Co-pay, Deductible venual services	SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: FINANCIAL Initial Limited Liability Company, for Podiatric Medical and Surgical services. SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: FUND Consense of the participates with Medicars, Medical and other commercial insurance companies. I acknowledge herewith, that you have valuntarily entered into a financial agreement with STRIDE FOOT RUE CENTER, L.C., a professional Limited Liability Company, for Podiatric Medical and Surgical services. SECTION 8: Consense of the service without exception and are your responsibility. If you do not have your co-payments on the sale of the participated services. This amount can be paid in cost desired the provided by an activate of the days of nay visit. SECTION 8: Consense of the first of the provider of the completion of your visit. A refund will be immediately yound not be deposit to reschadule your appointment for a later date. SECTION 8: Consense of the first of the completion of your visit. A refund will be immediately yound not be deposit to the charges exceed \$200, payments is dely your are proposable for full payment.	Secondary Insurance:	Policy Nur	nber:	
SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: undentualing of our financial policy is an essential pat of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT d.B CINTER, LLC, a professional Limited Liability Company, for Pediatric Medical adol Surgeoil services. SECTION 8: CONTER, LLC, a professional Limited Liability Company, for reductive Medical adol Surgeoil services and services the during lability of your responsibility. If you do not have you re-payment you may be asked to reschedule your appointment for a later date. If a publication of the proplate is not a simulation of \$200 prior to receiving services. This amount can be paid in cast dual time. If you can be provided by your group you may be asked to reschedule your appointment for a later date. If a publication is your wind the surface of your visit. A refund will be immediately your allowed to \$200 prior to receiving services. This amount can be paid in cast dual time. We want to be provided to your appointment for a later date. If you we require a depoint of \$200 prior to receiving services. This amount can be paid in cast dual time. We want to be provided by your appointment for a later date. If you we require a depoint of \$200 prior to receiving services. This amount can be paid in cast dual time. We want to be provided to your appointment for a later date. The provided is a provided	SECTION 5: PATIENT MEDICATION (attach medication list if more space needed) Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: undentualing of our financial policy is an essential pat of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT d.B CINTER, LLC, a professional Limited Liability Company, for Pediatric Medical adol Surgeoil services. SECTION 8: CONTER, LLC, a professional Limited Liability Company, for reductive Medical adol Surgeoil services and services the during lability of your responsibility. If you do not have you re-payment you may be asked to reschedule your appointment for a later date. If a publication of the proplate is not a simulation of \$200 prior to receiving services. This amount can be paid in cast dual time. If you can be provided by your group you may be asked to reschedule your appointment for a later date. If a publication is your wind the surface of your visit. A refund will be immediately your allowed to \$200 prior to receiving services. This amount can be paid in cast dual time. We want to be provided to your appointment for a later date. If you we require a depoint of \$200 prior to receiving services. This amount can be paid in cast dual time. We want to be provided by your appointment for a later date. If you we require a depoint of \$200 prior to receiving services. This amount can be paid in cast dual time. We want to be provided to your appointment for a later date. The provided is a provided	CECETON A PARTITION TO A CONTROL	ICAL WICHONY		
Allergies:	Allergies:	SECTION 4: PATIENT PAST MED	ICAL HISTORY		
Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT SECTION 8: CONSENT FOR PODIATRIC TREATMENT FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT SECTION 8: Consent For Podiatric Relation of Podiatric Relation Podical P	Allergies: Smoking: Yes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: SECTION 7: PHARMACY Name: Phone: Address: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT SECTION 8: CONSENT FOR PODIATRIC TREATMENT FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: SECTION 8: CONSENT FOR PODIATRIC TREATMENT SECTION 8: Consent For Podiatric Relation of Podiatric Relation Podical P				
Allergies: Smoking: Pes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: // Phone: Previous Podiatrist: Last seen: // Phone: SECTION 7: PHARMACY Name: Phone: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Date: Phone: Date: Signature (if applicable): Date: Signature: Date: Signature: Date: Signature: Date: Signature: Signatur	Allergies: Smoking: Pes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: // Phone: Previous Podiatrist: Last seen: // Phone: SECTION 7: PHARMACY Name: Phone: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Date: Phone: Date: Signature (if applicable): Date: Signature: Date: Signature: Date: Signature: Date: Signature: Signatur				
Allergies: Smoking: Pes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: // Phone: Previous Podiatrist: Last seen: // Phone: SECTION 7: PHARMACY Name: Phone: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Date: Phone: Date: Signature (if applicable): Date: Signature: Date: Signature: Date: Signature: Date: Signature: Signatur	Allergies: Smoking: Pes No Never If Yes, How long SECTION 6: PHYSICIAN INFORMATION Primary Physician: Last Seen: // Phone: Previous Podiatrist: Last seen: // Phone: SECTION 7: PHARMACY Name: Phone: City: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Date: Phone: Date: Signature (if applicable): Date: Signature: Date: Signature: Date: Signature: Date: Signature: Signatur				
Allergies:	Allergies:	SECTION 5: PATIENT MEDICATI	ON (attach medication list if more snace needed)		
Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: Previous Podiatrist: Last seen: Phone: Phone: Previous Podiatrist: Last seen: Phone: Ph	Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: Previous Podiatrist: Last seen: Phone: Phone: Previous Podiatrist: Last seen: Phone: Ph				
Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: Previous Podiatrist: Last seen: Phone: Phone: Previous Podiatrist: Last seen: Phone: Ph	Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: Previous Podiatrist: Last seen: Phone: Phone: Previous Podiatrist: Last seen: Phone: Ph		(under medicanen ust y more space necuca)		
Primary Physician: Last Seen: Phone: Previous Podiatrist: Last seen: Phone: Previous Podiatrist: Last seen: Phone:	Primary Physician:				
Primary Physician:	Primary Physician: Last Seen: / Phone: Previous Podiatrist: Last seen: / Phone: SECTION 7: PHARMACY Name: Phone: City: Zip: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Phone: Signature: Date: Seponsible Party/Guarantor's Signature (if applicable): Date: Seponsible Party/Guarantor's Signature (if applicable): Date: SecTION 8: Consent part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. SECTION 6: Consent participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. SECTION 6: CENTER, LLC, a professional Limit of Liability Company, for Podiatric Medical and Surgical services. This amount can be paid in cast dedit card. The fine and service with the deposit if the charges exceed \$200, payment is lat that time. Last Seen: / Phone: Pho		· · · · · · · · · · · · · · · · · · ·	□ Ne ver If Yes.	How long
Primary Physician:	Primary Physician: Last Seen: / Phone: Previous Podiatrist: Last seen: / Phone: SECTION 7: PHARMACY Name: Phone: City: Zip: Zip: SECTION 8: CONSENT FOR PODIATRIC TREATMENT Patient's Signature: Date: Phone: Signature: Date: Seponsible Party/Guarantor's Signature (if applicable): Date: Seponsible Party/Guarantor's Signature (if applicable): Date: SecTION 8: Consent part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. SECTION 6: Consent participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. SECTION 6: CENTER, LLC, a professional Limit of Liability Company, for Podiatric Medical and Surgical services. This amount can be paid in cast dedit card. The fine and service with the deposit if the charges exceed \$200, payment is lat that time. Last Seen: / Phone: Pho		· · · · · · · · · · · · · · · · · · ·	□ Ne ver If Yes,	How long
Previous Podiatrist:	Previous Podiatrist:	Allergies:	Smoking: ¬Yes ¬No	□ Ne ver If Yes,	How long
Previous Podiatrist:	Previous Podiatrist:	Allergies:	Smoking: ¬Yes ¬No	□ Ne ver If Yes,	How long
Name:	Name:	Allergies: SECTION 6: PHYSICIAN INFORM	Smoking: □Yes □ No		
Name:	Name:	Allergies:	Smoking: □Yes □ No [ATION] Last Seen://	Phone:	
Name:	Name:	Allergies:	Smoking: □Yes □ No [ATION] Last Seen://	Phone:	
Responsible Party/Guarantor's Signature (if applicable):	Responsible Party/Guarantor's Signature (if applicable):	Allergies:	Smoking: □Yes □ No [ATION] Last Seen://	Phone:	
Patient's Signature: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: runderstanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. Ree: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. St. All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is later that time. Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Patient's Signature: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: runderstanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. Rece: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. Signature: The Adrenation of the participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. Signature: The Adrenation of the participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. Signature: The Adrenation of the Adrenation of the provider of the participated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast dedit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. Life You are responsible for obtaining any necessary re	Allergies: SECTION 6: PHYSICIAN INFORM Primary Physician: Previous Podiatrist: SECTION 7: PHARMACY	Smoking: ¬Yes ¬No [ATION] Last Seen://Last seen://	Phone:Phone:	
Patient's Signature: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: runderstanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. Ince: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. See All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Patient's Signature: Responsible Party/Guarantor's Signature (if applicable): Date: FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: runderstanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. Ince: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. Six All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. Tred patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies:	Smoking: □Yes □ No ATION Last Seen:// Last seen:// Photo	Phone: Phone: Phone:	
FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: understanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. Nee: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible vered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. Six All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. The patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: runderstanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. **Rec:* Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. **S:* All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. **Ted patients:* if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. **Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies:	Smoking: □Yes □ No ATION Last Seen:// Last seen:// Photo	Phone: Phone: Phone:	
FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: understanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. Nee: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible vered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. Signal Co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. The patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast dedit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	FINANCIAL ACKNOWLEGDEMENT & AGREEMENT PLEASE READ CAREFULLY AND SIGN BELOW: understanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. Nee: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible vered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. Signal Co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. The patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast dedit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies:	Smoking: ¬Yes ¬No Last Seen:// Last seen:// City:	Phone: Phone: Phone:	
understanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. **Rec:** Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible vered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. **Extra Co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. **Red patients:** if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. **Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	runderstanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have <u>voluntarily</u> entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. **nee: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible overed services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. **Example 1.5 Example 2.5	Allergies: SECTION 6: PHYSICIAN INFORM Primary Physician: Previous Podiatrist: SECTION 7: PHARMACY Name: Address: SECTION 8: CONSENT FOR PODI Patient's Signature:	Smoking: ¬Yes ¬No ATION Last Seen:// Last seen:// Phore City: ATRIC TREATMENT Date:	Phone: Phone: Phone:	Zip:
understanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have voluntarily entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. **Rec:** Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible vered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. **Extra Co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. **Red patients:** if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. **Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	runderstanding of our financial policy is an essential part of your treatment. By signing this agreement you acknowledge herewith, that you have <u>voluntarily</u> entered into a financial agreement with STRIDE FOOT KLE CENTER, LLC, a professional Limited Liability Company, for Podiatric Medical and Surgical services. 10e: Our office participates with Medicare, Medicaid and other commercial insurance companies. I acknowledge that Stride Foot & Ankle Center, LLC will file my Insurance as a Courtesy. Any Co-pay, Deductible wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. 2s: All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. 1st you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is at that time. 1st You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies:	Smoking: ¬Yes ¬No ATION Last Seen:// Last seen:// Phore City: ATRIC TREATMENT Date:	Phone: Phone: Phone:	Zip:
vered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. St. All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	overed services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. 83: All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. 10: If you do not have your co-payment you may be asked to reschedule your appointment for a later date. 11: If you do not have your co-payment you may be asked to reschedule your appointment for a later date. 12: If you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast redit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is dat that time. 12: You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies:	Smoking: □Yes □ No Last Seen:// Last seen:/_/ Phore City: ATRIC TREATMENT Date: ature (if applicable):	Phone:Phone:	Zip:
vered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. St. All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is lat that time. You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	wered services and medical supplies are my responsibility. I will be asked to pay for non-covered items and services the day of my visit. 15: All co-payments are due at the time of service without exception and are your responsibility. If you do not have your co-payment you may be asked to reschedule your appointment for a later date. 15: The patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cast edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is at that time. 16: You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies:		Phone:Phone:Phone:Phone:	Zip:
red patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cash edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is at that time. 1. You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	red patients: if you are uninsured, a free estimate of expected charges based on anticipated services will be provided to you. We require a deposit of \$200 prior to receiving services. This amount can be paid in cash edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is d at that time. 1 You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies:	Smoking: □Yes □ No [ATION] Last Seen:/ Last seen:/_ Last seen:/_ Phore City: ATRIC TREATMENT Date: ature (if applicable): KNOWLEGDEMENT & AGREEMENT PLEASE READ treatment. By signing this agreement you acknowledge herewith, that you have yol for Podiatric Medical and Surgical services.	Phone: Phone: Date: CAREFULLY AND SIGN untarily entered into a finance	Zip:
edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is at that time. Let You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	edit card. The final charge will be determined by the provider at the completion of your visit. A refund will be immediately issued should the charges be less than the deposit. If the charges exceed \$200, payment is 1 at that time. 12 You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies: SECTION 6: PHYSICIAN INFORM Primary Physician: Previous Podiatrist: SECTION 7: PHARMACY Name: Address: SECTION 8: CONSENT FOR PODI Patient's Signature: Responsible Party/Guarantor's Signa FINANCIAL ACI r understanding of our financial policy is an essential part of your KLE CENTER, LLC, a professional Limited Liability Company, nee: Our office participates with Medicare, Medicaid and other convered services and medical supplies are my responsibility. I will 1		Phone: Phone: Dat CAREFULLY AND SIGN untarily entered into a finance. C will file my Insurance as a	Zip: [BELOW: cial agreement with STRIDE FOOT a Courtesy. Any Co-pay, Deductible
11: You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	al: You are responsible for obtaining any necessary referral if required by your insurance company. If referral is not obtained and is necessary, you are responsible for full payment.	Allergies: SECTION 6: PHYSICIAN INFORM Primary Physician: Previous Podiatrist: SECTION 7: PHARMACY Name: Address: SECTION 8: CONSENT FOR PODI Patient's Signature: Responsible Party/Guarantor's Signa FINANCIAL ACI Trunderstanding of our financial policy is an essential part of your KLE CENTER, LLC, a professional Limited Liability Company, age: Our office participates with Medicare, Medicaid and other convered services and medical supplies are my responsibility. I will 1 signal to 2 payments are due at the time of service without exception red patients: if you are uninsured, a free estimate of expected christics: if you are uninsured, a free estimate of expected christics: if you are uninsured, a free estimate of expected christics: if you are uninsured, a free estimate of expected christics.	Smoking: ¬Yes ¬No Last Seen:/ Last seen:/_ Last seen:/_ Phor City: ATRIC TREATMENT Date: MILITIAN Phor City: MATRIC TREATMENT The seed of applicable is ENOWLEGDEMENT & AGREEMENT PLEASE READ AGR	Phone: Phone: Phone: Dat CAREFULLY AND SIGN Intarily entered into a finance C will file my Insurance as a d to reschedule your appoints \$200 prior to receiving servi-	Zip: [BELOW: cial agreement with STRIDE FOOT a Courtesy. Any Co-pay, Deductible ment for a later date. ces. This amount can be paid in casl
	ve read, understood and accept the terms stated above.	Allergies: SECTION 6: PHYSICIAN INFORM Primary Physician: Previous Podiatrist: SECTION 7: PHARMACY Name: Address: SECTION 8: CONSENT FOR PODI Patient's Signature: Responsible Party/Guarantor's Signa FINANCIAL ACI r understanding of our financial policy is an essential part of your KLE CENTER, LLC, a professional Limited Liability Company, ace: Our office participates with Medicare, Medicaid and other convered services and medical supplies are my responsibility. I will I signal I co-payments are due at the time of service without exceptive departiculars; if you are uninsured, a free estimate of expected che dit card. The final charge will be determined by the provider at the distance of the provider at	Smoking: ¬Yes ¬No Last Seen:/ Last seen:/_ Last seen:/_ Phor City: ATRIC TREATMENT Date: MILITIAN Phor City: MATRIC TREATMENT The seed of applicable is ENOWLEGDEMENT & AGREEMENT PLEASE READ AGR	Phone: Phone: Phone: Dat CAREFULLY AND SIGN Intarily entered into a finance C will file my Insurance as a d to reschedule your appoints \$200 prior to receiving servi-	Zip: [BELOW: cial agreement with STRIDE FOOT a Courtesy. Any Co-pay, Deductible ment for a later date. ces. This amount can be paid in casl

Fax Completed Form to: Goodness Mayembe, Practice Manager. FAX # 678-926-3550 or call 678-288-9205 for further assistance

Patient Signature/Responsible Party