



CONFIDENTIAL PATIENT INFORMATION  
PLEASE PRINT

PATIENT INFORMATION

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP): \_\_\_\_\_  
LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: \_\_\_\_\_ SS# \_\_\_\_\_ STATUS: SINGLE MARRIED OTHER  
EMAIL: \_\_\_\_\_ HM PHONE: \_\_\_\_\_  
*May we email you? YES NO* *May we leave a message? YES NO*  
EMPLOYER: \_\_\_\_\_ WK PHONE: \_\_\_\_\_  
*May we leave a message? YES NO*  
EMERGENCY CONTACT: \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Language \_\_\_\_\_  
Full Name & Phone Number *Allow Privileged Information?: YES NO*

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE: \_\_\_\_\_  
INSURED PERSON: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
SS # \_\_\_\_\_  
ID# \_\_\_\_\_  
GROUP/POLICY # \_\_\_\_\_  
SEX: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
Allow Privileged Information?: YES NO

AUTHORIZATION TO RELEASE INFORMATION

I HEARBY AUTHORIZE HEATHER MCCOMBS, DPM LLC TO USE MY HEALTH CARE INFORMATION & DISCLOSE SUCH INFORMATION TO APPROPRIATE INSURANCE(S) & THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES & DETERMINING INSURANCE BENEFITS. I AUTHORIZE HEATHER MCCOMBS, DPM LLC TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MEDICAL & OTHER PERSONNEL WHO MAY PARTICIPATE IN MY CARE. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL I REVOKE SAID AUTHORIZATION BY GIVING WRITTEN NOTICE.

\_\_\_\_\_  
(SIGNATURE PATIENT OR PARENT IF MINOR) DATE \_\_\_\_\_

AUTHORIZATION OF PAYMENT TO PHYSICIAN

I HEARBY ASSIGN ALL INSURANCE BENEFITS DIRECTLY TO HEATHER MCCOMBS, DPM LLC, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY LIABLE FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE PAYMENT. HEATHER MCCOMBS, DPM LLC DOES NOT WAIT FOR SETTLEMENT FROM LAWSUITS. YOU ARE RESPONSIBLE FOR PAYING FOR SERVICES WHILE IN LITIGATION.

\_\_\_\_\_  
(SIGNATURE PATIENT OR PARENT IF MINOR) DATE \_\_\_\_\_

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE: \_\_\_\_\_  
INSURED PERSON: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
SS #: \_\_\_\_\_  
ID# \_\_\_\_\_  
GROUP/POLICY#: \_\_\_\_\_  
SEX: \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_

CANCELLATION POLICY

BY SIGNING BELOW, I UNDERSTAND THAT APPOINTMENT CANCELLATIONS MUST BE DONE BY 4:30 PM THE BUSINESS DAY PRIOR TO MY SCHEDULED APPOINTMENT. IF I FAIL TO DO SO, I WILL BE CHARGED FOR A NO-SHOW FEE OF \$25.00. HEATHER MCCOMBS, DPM LLC RESERVES THE RIGHT TO CHARGE FOR NO-SHOW APPOINTMENTS & RESERVES THE RIGHT TO CHANGE THIS POLICY AT ANY TIME.

\_\_\_\_\_  
(SIGNATURE PATIENT OR PARENT IF MINOR) DATE \_\_\_\_\_

HIPPA

BY SIGNING BELOW, I HAVE RECEIVED & READ THE HIPPA PRIVACY INFORMATION SHEET THAT WAS PROVIDED TO ME.

\_\_\_\_\_  
(SIGNATURE PATIENT OR PARENT IF MINOR) DATE \_\_\_\_\_

COLLECTION FEES

I ACKNOWLEDGE THAT IF MY ACCOUNT IS TURNED OVER TO COLLECTIONS, I WILL BE RESPONSIBLE FOR ANY COST, FEES, AND ATTORNEY FEES INCURRED IN COLLECTIONS TO OBTAIN PAYMENT FOR SERVICES RENDERED.

\_\_\_\_\_  
(SIGNATURE PATIENT OR PARENT IF MINOR) DATE \_\_\_\_\_