ACTIVE FOOT & ANKLE CARE, LLC
RICHARD T. BRAVER, D.P.M.
GREGORY S. TAMAGNINI, D.P.M.
PHILIP S. MESSENGER, D.P.M.
4-14 Saddle River Road, Fair Lawn, N.J. 07410 201-791-1881
44 Route 23 North, Riverdale, NJ 07457 973-831-1774

WELCOME TO OUR OFFICE

PATIENT INFORMATION:
SEX: MALE [ ] FEMALE[ ]

BIRTH DATE: ______/_____/________

SOCIAL SECURITY# _________-__________-__________

LAST NAME: ________________________________

FIRST NAME: ______________________ M.I. _____

ADDRESS: ________________________________

CITY: ______________ STATE: ______ ZIP: ________

HOME PHONE: ( ) ________________________

WORK PHONE: ( ) ________________________

CELL PHONE ( ) ________________________

INSURED'S INFORMATION
EMPLOYER OF INSURED:_______________________
YOUR RELATIONSHIP TO INSURED:
SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
INSURED PERSON : [ ] MALE FEMALE [ ]
INSURED'S NAME (if other than self):

LAST NAME: ________________________________

FIRST NAME: ______________________ M.I. _____

ADDRESS: ________________________________

CITY: ______________ STATE: ______ ZIP: ______

HOME PHONE: ( ) ________________________

WORK PHONE: ( ) ________________________

DATE OF BIRTH : ____________________________

SOCIAL SECURITY # : ________/_______/_______

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_______________________________________
IDENTIFICATION #_____________________________ Group # _____________

SECONDARY INSURANCE NAME:_____________________________________
IDENTIFICATION #_____________________________ Group # _____________

HOW WILL YOU BE PAYING TODAY?
CHECK [ ] CASH [ ] VISA/MC/AMEX [ ] WORKMEN'S COMP [ ] MVA [ ] COPAY AMOUNT ___________

Credit Card # ______________________________ Exp date:_____________

IF OTHER THAT THE ABOVE PLEASE DISCUSS PAYMENT WITH THE OFFICE RECEPTIONIST

AUTHORIZATION / RESPONSIBILITY AGREEMENT;
I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY BENEFITS TO DR. RICHARD T. BRAVER, AND / OR ASSOCIATES AND WILL BE RESPONSIBLE FOR THE REMAINING BALANCE . A COPY OF THIS FORM CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

I HEREBY AGREE TO PAY MY ACCOUNT AS SERVICES ARE PROVIDED. HOWEVER, IF I AM NOW OR IN THE FUTURE BECOME A MEMBER OF A HMO OR MANAGED CARE PLAN I WILL PROVIDE PROPER AUTHORIZATION OR REFERRALS FOR THIS AND UPCOMING VISITS. SHOULD MEDICAL CARE BE GIVEN AND PROPER AUTHORIZATION OR REFERRAL NOT OBTAINED, I AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO ACTIVE FOOT AND ANKLE CARE, LLC .

UNDER CERTAIN CIRCUMSTANCES, I MAY HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF; I CLEARLY UNDERSTAND THAT THE BILL IS STILL MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS). IF FOR ANY REASON ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I AGREE TO PAY PROMPTLY. ANY OUTSTANDING BILLS MAY BE SUBJECT TO MONTHLY LATE FEE OR SENT TO A BILLING AGENCY.

FURTHERMORE, SHOULD YOUR ACCOUNT BE TURNED OVER TO A COLLECTION AGENCY, THEN YOU WILL BE RESPONSIBLE FOR AN ADDITIONAL CHARGE OF 33.3% OF THE DEBT.

SIGNED:______________________________________DATE:________________
Save as: welcome 2015