

PATIENT UPDATE FORM

***MUST BE COMPLETED IF YOU HAVE NOT SEEN DR. PETERSON IN THE
LAST 3 MONTHS***

DATE _____ HOME PHONE _____ CELL PHONE _____

PATIENTS NAME _____

ADDRESS _____

BIRTHDATE _____ AGE _____ WEIGHT _____ SHOE SIZE _____

EMAIL ADDRESS _____

FAMILY DOCTOR _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____

INSURANCE COMPANY _____

CARDHOLDER NAME _____ DATE OF BIRTH _____

PLEASE READ THE FOLLOWING: I hereby give my permission for Dr. Gerald Peterson and/or his assistants to administer treatment as may be deemed necessary in the diagnosis and/or treatment of any podiatric medical condition.

OFFICE POLICIES

All non-covered services are due at the time of service. As a courtesy to me, my insurance claim will be processed provided all necessary information is presented. I understand that if my insurance company requires that my primary physician refer me to Dr. Peterson and I have not obtained that referral, that any and all charges incurred will be my responsibility. I also understand that I must notify Dr. Peterson of any need to pre-authorize treatment and I accept responsibility for all charges when pre-authorization is not obtained. **COPAYMENTS ARE DUE AT THE TIME OF SERVICE.** Statements are sent out monthly. My account will be assessed a rebilling charge of \$5.00 per month for any balance over 60 days. Balances are not carried over 90 days. If my insurance company has not paid within that time frame, the balance over 90 days will become my responsibility. If payment does not result, my account will be assigned to collections. I understand that if it becomes necessary to use outside collection efforts to bring my account to a paid status, that I will be charged and all collection costs at the time the account is assigned. Also, I hereby authorize any insurance benefits to be payable directly to the physician. I am financially responsible for all non-covered charges. I also authorize the physician to release any medical information necessary in processing my insurance claim to my insurance company. A charge of \$30.00 will be added to all returned checks.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON _____