

CHANGE OF ADDRESS:

Received \_\_\_\_\_ NP \_\_\_\_\_

Old Zip Code \_\_\_\_\_  
New Zip Code \_\_\_\_\_

2022

**TFFA PATIENT INFORMATION FORM**

(Please Print)

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Apt/Sp # \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ SS # \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Contact/CG \_\_\_\_\_ Phone \_\_\_\_\_ Place of Service \_\_\_\_\_

ACP/Medical POA \_\_\_\_\_ Phone \_\_\_\_\_

Guar./Financial Responsibility \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Email Address \_\_\_\_\_ Referred by \_\_\_\_\_

PCP \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**PRIMARY INSURANCE**

HOSPICE: \_\_\_\_\_

COMPANY \_\_\_\_\_ POLICY# (NEW) \_\_\_\_\_ (OLD) \_\_\_\_\_

Phone \_\_\_\_\_ Insured Name \_\_\_\_\_ Insured Employer \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured Age \_\_\_\_\_ Insured Home Phone \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ VERIFIED:  YES  NO \_\_\_\_\_ DATE: \_\_\_\_\_

**SECONDARY INSURANCE**

COMPANY \_\_\_\_\_ POLICY # \_\_\_\_\_

GROUP# \_\_\_\_\_ AUTHORIZATION # \_\_\_\_\_

Phone \_\_\_\_\_ Insured Name \_\_\_\_\_ Insured Employer \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured Age \_\_\_\_\_ Insured Home Phone \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Financial Hardship Statement:** I am Verified **Hospice-QMB** or **MC-QMB** and, due to financial hardship am **unable** to pay a copy or any balance due over \$ \_\_\_\_\_ at this time. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Financial Agreement and Authorization for Treatment:**

I authorize treatment of the above and agree to pay all fees and charges for each treatment. I do understand the financial responsibility for payment is my responsibility regardless of insurance, including annual Medicare deductibles and copays. I also hereby assign and authorize any payment to be made directly to ToeTai Family Foot Care Associates. I authorize the **RELEASE OF PERSONAL MEDICAL RECORDS** of treatment from my primary care physician, from my insurance company, and attorneys in connection with the above assignments. I understand that payment for services are due upon treatment. You are entitled to a copy of this agreement at the time you sign.

We reserve the right to charge for appointments cancelled or broken without 24-hour notice, as well as a "no show" fee of \$40.00 when the doctors arrive and patient is not home after confirming appointment. We also reserve the right to charge for any surgery cancelled or broken without 72-hour notice.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

I currently have a copy of my:

NEW MEDICARE CARD:  YES  NO \_\_\_\_\_ initials

SECONDARY INSURANCE CARD:  YES  NO

OLD MEDICARE CARD:  YES  NO \_\_\_\_\_ initials