

Sextro-Larsen Podiatry, PC
Philip B. Sextro, DPM, Kevin J. Larsen, DPM Scot W. Bandel, DPM
Please present your insurance card to receptionist

Date: _____ Date of Birth _____ Age _____ Sex: M F

Patient: _____
(Last Name) (First Name) (Middle Initial)

Home Address: _____
(Street) (City) (State) (Zip Code)

Home Phone _____ Cell Phone _____ SS# _____

Please circle: Married Single Widow Divorced

Patient Employer _____ Work Phone _____

Employer Address _____

Name of Spouse or Parent _____

Date of Birth _____ SS# _____

Spouse Employer _____ Phone _____

Employer Address: _____

Whom can we thank for this referral _____

Is this Workmen's Compensation Related: Yes No

Authorization of Benefits

I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to Sextro-Larsen Podiatry, PC for the services described on the claim form submitted.

Patient Signature _____

Medicare Signature on File and Medigap Assignment of Benefits

I request that payment of authorized Medicare benefits be made to Sextro-Larsen Podiatry, PC for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I hereby authorize payment of my Medigap benefits to this provider for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____ Date _____

**Sextro-Larsen Podiatry, PC
Grand Island Foot Clinic
620 N Diers Ave PO Box 5020
Grand Island, NE 68802**

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Patient Financial Policy

Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or office manager.

As our patient, you are responsible for all referrals needed to seek treatment in this office. Our office will do all pre-certification for surgical procedures and certain other procedures.

Unless other arrangements have been made in advance, payment for office services are due at the time of service. We accept Visa, Mastercard, American Express, check or cash. If you have insurance, we will bill those plans and you will be responsible for the co-pay, co-insurance or deductible at the time of service.

Your insurance is a contract between you and your insurance company. We will file your insurance claim for you when you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "Not Covered", you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services however you remain responsible for charges to any service rendered. Patients are encouraged to contact their health care plan for clarification of benefits if they have questions regarding services.

For any services provided in the hospital or surgical center, we will pre-authorize your surgery and we will bill your health care plan. Any balance due is your responsibility.

There are certain elective procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due prior to the procedure.

Past due accounts are subject to interest charges and collection procedures. Any account 90 days old will be charged at "periodic rate" of 1.2% per month (annual rate of 14%). Any account not collectible by our office will be filed with a collection service for collection procedures.

There is a service fee of \$20.00 for all returned checks.

Signature of Patient _____ Date _____

Printed Name of Patient/Responsible Party _____ Date _____