

**PLEASE GIVE US ALL PERTINENT INFORMATION REGARDING YOUR INSURANCE  
COVERAGE. IF YOU HAVE MORE THAN ONE INSURANCE CARRIER, SUPPLY  
INFORMATION FOR BOTH CARRIERS**

**HEALTH PLAN INFORMATION**

**PRIMARY INSURANCE**

Name of Insurance Co \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Group Name \_\_\_\_\_

**\*\*IF THE SUBSCRIBER IS NOT THE PATIENT \*\*** Subscriber Name: \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's Social Security Number \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insurance Co \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Group Name \_\_\_\_\_

**\*\*IF THE SUBSCRIBER IS NOT THE PATIENT \*\*** Subscriber Name: \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's Social Security Number \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

**ALL PATIENTS**

**I hereby authorize Midwest Orthopedics Foot & Ankle, PC to release medical information necessary for insurance reimbursement. I hereby authorize and assign payment directly to Midwest Orthopedics Foot & Ankle, PC of insurance benefits herein specified and otherwise payable to me. I understand that I am financially responsible to Midwest Orthopedics Foot & Ankle, PC for all charges incurred regardless of potential insurance benefits. I understand that if payment is not made in the full amount of the charges incurred or if the payment is not received in a timely manner, the entire balance due may be turned over to a professional collection agency or attorney and fees will be assessed. I also authorize Midwest Orthopedics Foot & Ankle, PC, to release medical information to my referring physician, primary care physician and any physician to whom the physician's at Midwest Orthopedics Foot & Ankle, PC, refer me, for the purpose of medical treatment. I also agree that at the time of my initial visit the office staff will require a prepayment of any deductibles not already met based upon my insurance plan. I understand that this does not mean I have paid my bill in full, but am paying a portion of what charges are incurred. If I have any questions in regards to this I will ask at the time of my visit and agree to pay as requested.**

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_

**MEDICARE PATIENTS ONLY**

I hereby authorize payment of my Medicare and benefits to Midwest Orthopedics Foot & Ankle, PC for all claims filed in my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient Signature: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_