ALPINE FOOT SPECIALISTS, P.C.
765 ELA ROAD – SUITE 100
LAKE ZURICH, IL 60047
TELEPHONE (847) 540-9949
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alpinefootspecialists@yahoo.com

Anna C. Gurrera,D.P.M.
Jehanzab Siddiqui, D.P.M.

PATIENT COMMUNICATION AGREEMENT

____ ____/____/____
Patient's Name: Last First Middle Initial Date of Birth

____
Address City State Zip Code

Phone: Home (___)_____________ Work (_______)___________Cell (_______)___________________

SSN: _________________________

Which # do you prefer communication? ☐ Home ☐ Work ☐ Cell

In accordance with HIPAA, please answer the following questions:

May we leave messages on your voice mail or answering machine? ☐ Yes ☐ No

May we leave messages with any other person and/or do you authorize any other person to call regarding your medical information? ☐ Yes ☐ No

If Yes, with whom? _________________________ Relationship __________ (______)__________
Phone

If Yes, with whom? _______________________ Relationship ___________(______)__________
Phone

May we call you at work? ☐ Yes ☐ No

Emergency Contact: ___________________ Relationship: _________________ (______)_____________
Phone

Pharmacy of Choice: ___________________ Town and Street of Pharmacy: _______________________

Primary Care Physician: ________________________ Phone Number: (_____) _____________________

Patient's Email Address: ____

How did you hear about Alpine Foot Specialists?____

TURN TO THE BACK PLEASE →

Please initial each section. **PATIENT NAME: ______________________________**

_________**(Initial)** I understand there is a $50.00 "**No-Show**" if I do not provide a minimum of 24-hours' notice of my intent not to appear at a scheduled appointment.

_________**(Initial)** I hereby authorize Alpine Foot Specialists, to release to my insurance company, third party insurance, or their medical review companies, all medical information necessary to secure payment of medical services. I hereby authorize payment of all medical/surgical insurance benefits, to be directly to Alpine Foot Specialists. ***I understand I will be fully responsible for payment of any charges not covered by medical insurance.***

_________**(Initial)** Payment for services may be made by credit card, approved check, or cash. ***Returned checks will be issued a $35.00 return fee.***

_________**(Initial)** **UNPAID BALANCES AFTER 60 DAYS WILL BE SUBJECT TO $25.00 PER MONTH LATE FEE.** Accounts 4 months and older, may require ***COLLECTION AGENCY ACTION*** if an agreement between Alpine Foot Specialists and myself has not been formally arranged. ***ALL COLLECTIONS FEES WILL BE MY (PATIENT) RESPONSIBILITY .***
IN THE EVENT YOUR ACCOUNT IS SENT TO COLLECTIONS. THE COLLECTION FEE OF $100.00 WILL BE ADDED TO YOUR ACCOUNT.

_________**(Initial)** **INSURANCE POLICIES DETERMINE MEDICAL COVERAGE.** THERE ARE MANY DIFFERENT PLANS. INDEPENDENT OF EACH OTHER, WITHIN THE SAME INSURANCE COMPANY. ***IT IS MY (PATIENT) RESPONSIBILITY TO UNDERSTAND MY MEDICAL COVERAGE INCLUDING BUT NOT LIMITED TO: (1) DEDUCTIBLES. (2) COINSURANCE AND COPAYMENTS. (3) SERVICES THAT REQUIRE A REFERRAL. ANY SERVICES, OR REFERRALS RECOMMENDED BY OUR DOCTORS ARE MADE STRICTLY FOR MEDICAL PURPOSES.***

_________**(Initial)** Patients with high deductibles will be asked for $100.00 payment per visit until the deductibles will be met.

PRIVACY POLICY

The HIPAA notice has been made available to me by Alpine Foot Specialists
My signature is confirmation that I understand, and initial each section listed above.

Signature ____ Date ____________________________

Patients will have 60 days to review and remit payment on outstanding balances. After 60 days, a $25.00 Late Charge will be applied. Any dispute of balances must be made no later than 60 days from the date of service, or 60 days from the date your insurance makes final adjudication of your claim. After 90 days, unpaid balances will automatically be charged to your credit card account.

REQUIRED CREDIT CARD# __________________________ Expiration Date ____/____/____ Authorization Code: _________
(3 digits on back side of card. If Am Ex. 4 digits on front)

Signature ____ Date __________________