



**ALPINE FOOT SPECIALISTS, P.C.**

765 ELA ROAD – SUITE 100  
LAKE ZURICH, IL 60047  
TELEPHONE (847) 540-9949  
FAX (847) 540-9971  
[alpinefootspecialists@yahoo.com](mailto:alpinefootspecialists@yahoo.com)

**Anna C. Gurrera, 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: \_\_\_\_\_ Profession: \_\_\_\_\_

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 \_\_\_\_\_