ACTIVE FOOT & ANKLE CARE, LLC

RICHARD T. BRAVER, D.P.M.
PHILIP S. MESSENGER, D.P.M.
4-14 Saddle River Road Fair Lawn, N.J. 07410
44 Route 23 North, Riverdale, NJ 07457
Tel: (201) 791-1881 Fax: (201) 791-6177

WELCOME TO OUR OFFICE

PATIENT INFORMATION:
SEX: MALE [ ] FEMALE [ ]

BIRTH DATE: _____/_____/_____

SOCIAL SECURITY# _____-_____-_____

LAST NAME: _____

FIRST NAME: _____ M.I. ____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

CELL PHONE ( ) _____

INSURED'S INFORMATION
EMPLOYER OF INSURED: _____
YOUR RELATIONSHIP TO INSURED:
SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
INSURED PERSON: [ ] MALE FEMALE [ ]
INSURED'S NAME (if other than self):

LAST NAME: _____

FIRST NAME: _____ M.I. ____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____/_____/_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____
IDENTIFICATION # _____ Group # _____

SECONDARY INSURANCE NAME: _____
IDENTIFICATION # _____ Group # _____

_____Initial ***MUST CALL 24 HOURS IN ADVANCE TO CANCEL / RESCHEUDULE APPOINTMENT, THERE WILL BE A CHARGE OF $25.***

AUTHORIZATION / RESPONSIBILITY AGREEMENT;

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY THE PROCEEDS OF ANY BENEFITS TO DR. RICHARD T. BRAVER, AND / OR ASSOCIATES AND WILL BE RESPONSIBLE FOR THE REMAINING BALANCE. A COPY OF THIS FORM CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

I HEREBY AGREE I HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF FOR SERVICES PROVIDED. I UNDERSTAND THAT THE BILL IS MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS) AND AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO ACTIVE FOOT & ANKLE CARE LLC.

I HEREBY AGREE ANY OUTSTANDING BILLS WILL BE SUBJECT TO A LATE FEE NOT TO EXCEED $250 WHEN SENT TO A BILLING AGENCY FOR COLLECTION.

FOR OUT OF NETWORK PATIENTS, YOUR INSURANCE CARRIER MAY BE ISSUING PAYMENT DIRECTLY TO YOU FOR ANY SERVICES RENDERED AT OUR OFFICE ALONG WITH AN EXPLANATION OF PAYMENT SUMMARY. I HEREBY AGREE PAYMENT AND EXPLANATION SUMMARY WILL BE FORWARDED TO ACTIVE FOOT & ANKLE CARE, LLC PROMPTLY. PAYMENT EXCEEDING 30 BUSINESS DAYS FROM THE DATE OF CHECK ISSUANCE MAY RESULT IN LATE FEES. IF PAYMENTS ARE NOT FORWARDED TO OUR OFFICE, YOU THE PATIENT/GUARANTOR WILL BE FULLY LIABLE FOR FULL CHARGES BILLED, INCLUDING DEDUCTIBLE, CO-PAYS AND CO-INSURANCE WHEN SENT TO A BILLING AGENCY FOR COLLECTION.

SIGNED: _____ DATE: _____

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