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 201-791-1881
44 Route 23 North, Riverdale, NJ 07457 973-831-1774

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 TO PAY MY ACCOUNT AS SERVICES ARE PROVIDED. HOWEVER, IF I AM NOW OR IN THE FUTURE BECOME A MEMBER OF A HMO OR MANAGED CARE PLAN I WILL PROVIDE PROPER AUTHORIZATION OR REFERRALS FOR THIS AND UPCOMING VISITS. SHOULD MEDICAL CARE BE GIVEN AND PROPER AUTHORIZATION OR REFERRAL NOT OBTAINED, I AGREE TO PAY ANY OUTSTANDING BALANCE DIRECTLY TO ACTIVE FOOT AND ANKLE CARE CENTER.

UNDER CERTAIN CIRCUMSTANCES, I MAY HAVE ARRANGED FOR THE DOCTOR TO BILL MY INSURANCE COMPANY ON MY BEHALF; I CLEARLY UNDERSTAND THAT THE BILL IS STILL MY RESPONSIBILITY AND I WILL MAKE SURE THE BILL IS PAID IN A REASONABLE TIME FRAME (45 DAYS). IF FOR ANY REASON ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I AGREE TO PAY PROMPTLY. ANY OUTSTANDING BILLS MAY BE SUBJECT TO A MONTHLY LATE FEE OR SENT TO A BILLING AGENCY AND A 33% SERVICE FEE WILL BE ADDED.

SIGNED: _____ DATE: _____

Save as: welcome 2018