Patient's First Name _____ Last Name_____

Home Address_____City_____State_____Zip_____

Home Phone (____)_____ Work(____)_____ Cell(____)_____

Marital Status: (Please circle) S M Sep D W DP Sex: M or F

Date of Birth _____/_____/_____ *required* SS# _____/_____/_____

Email:_____Employer Name_____Occupation_____

In addition to the information below - WE MUST HAVE A COPY OF YOUR INSURANCE CARD!

Primary Insurance_____ Policy Holder's Name_____

Insured's DOB_____/_____/_____ Sex: M or F Relationship Spouse Parent Other_____

Secondary Insurance_____ Policy Holder's Name_____ Insured's DOB_____/_____/_____Sex: M or F Relationship Spouse Parent Other_____

If a patient is a MINOR, please provide name and address, (if different) of responsible party:

Name _____Address _____ Other_____

REFERRED BY :DR. _____ Website Insurance Sign Yelp Lecture Family Prior Patient

Please Note- There is a $65.00 fee for any broken, missed, or cancelled appointments unless a 48 hour advance notice is given.

Patient Initials _____

If you do not provide the correct insurance information at the time of your visit, we will be unable to bill your insurance and you will be responsible for your payment in full.

Co-payments are due at the time of service. We will bill all contracted insurance companies, however you are ultimately Responsible for all charges whether or not paid by your insurance. For your convenience, we accept Cash, Checks, and Credit Cards. To avoid late payment fees or finance charges all unpaid balances are your responsibility within 30 days from the date of Service.

Dr.Robinson may inform your other physicians of your podiatric condition to facilitate continuity of care.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

If your account becomes delinquent (past due), we may take the following actions: (1) refer your account to a collection agency, (2) file a lawsuit to recover the amount owed. If your account is referred to a collection agency, you agree to pay a collection fee and interest at an annual rate of 10% on the unpaid balance, beginning 30 days after the date of service. If legal action is required to collect the amount owed, you agree to pay all reasonable attorney's fees and court costs incurred in the collection process, in addition to the outstanding balance, collection fees, and interest.

I here by assign and request that my insurance benefits be paid directly to Douglas Robinson DPM, PPC. I also authorize the office to release any information required to process my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original. My signature below indicates that I have read, understand, and agree to the office policies. The HIPPA policy is available to review in the office and at my request a copy will be given to me to take home.

Signed_____ Date _____07.01.2025