



Midwest Foot & Ankle, PC

Jon R. Goldsmith, DPM

Demographic Information

Patient Name _____ Date of Birth ____/____/____
Home Address _____ Apt #/PO Box _____
City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____
Social Security #: _____ Age _____ Sex: Male ____ Female ____

Patient Employer

Employer _____ Occupation _____

Primary Insurance

Primary Insurance Name _____
Name of policy holder _____
Relationship to Patient _____
Policy Holder's Date of Birth ____/____/____ Social Security Number _____ - _____ - _____
Are you covered by another insurance? Yes ____ No ____

Secondary Insurance

Primary Insurance Name _____
Name of policy holder _____
Relationship to Patient _____
Policy Holder's Date of Birth ____/____/____ Social Security Number _____ - _____ - _____

Midwest Foot & Ankle, PC

7643 Cass Street
Omaha, NE 68114

Phone (402) 933-8540 Fax (402) 933-8578



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Assignment of Benefits & Authorization to Release Information to My Insurance Company

I, the undersigned certify that I (or my dependent) have insurance coverage with the above plan(s), and hereby assign all insurance benefits, if any, otherwise payable to me, directly to **Midwest Foot & Ankle, PC** for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company(ies).

I authorize the use of my signature below to reflect my agreement and authorization for the above for all insurance submissions.

Responsible Party Signature _____

Relationship to Patient _____ Date ____/____/____

Medicare Authorization

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf directly to **Midwest Foot & Ankle, PC** for services rendered. I hereby authorize the doctor to release to the Centers of Medicare and Medicaid Services (CMS) all information necessary to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Section 9 of the HCFA 1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, copayment, and charges associated with non-covered services. Copayments and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date ____/____/____

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