Comprehensive Foot & Ankle Centers

Christopher W. Hubbard, DPM Joshua R. Coger, DPM Samual P. Gracey, DPM

Westport Plaza
9407 Westport Rd., Ste. 110
Louisville, KY 40241
502.797.3338 (O)
502.919.7710 (F)

Jewish Medical Center South
1905 W. Hebron Ln., Ste. 204
Shepherdsville, KY 40165
502.797.3338 (O)
502.957.1731 (F)

Patient Information

First Name: ____________________ M.I.:____ Last Name:_____________________ Suffix:____ Sex: M □ F □

SSN:____ - ___ - _______ Date of birth: ____/____/______ Age:____ Email:___________________________

Street Address:____ Apt./Suite_______________

City:____ State:_____________ Zip Code:____________

Home Phone:___________________ Work Phone:___________________ Cell Phone:____________________

Primary Care Physician:_______________________ Referring Physician:_______________________________

Primary Language: ______________ Race: □ White □ Asian □ Black □ Other Ethnicity:□ Non-Hispanic □ Hispanic/Latino

Marital Status: __________________ Are you a student: _____ Are you employed:______

Name of Employer:____

Employer Address:____

Employer Phone:____

Emergency Contact Name: ____________________

Phone: ____________________

Primary Insurance Name:____Effective Date:__________

Secondary Insurance Name: ____Effective Date:__________

Name of Policy Holder/Guarantor:______________________________ Relation to Patient:____________________

Policy holder/Guarantor's SSN:____ - ___ - _______ Policy holder/Guarantor's Date of birth: ____/____/______

I give my consent for Comprehensive Foot and Ankle Centers, INC to remind me of my scheduled appointment by using an automated reminder program. I understand that this message may include the physician's name and the date/time of my appointment. It may be delivered to an answering machine or anyone who should answer the telephone.

I hereby authorize professional services rendered by Christopher Hubbard, DPM, Joshua Coger, DPM, or Samual Gracey, DPM. If insurance is filed, I authorize and assign insurance payment directly to the physicians. I understand that I am responsible for all amounts not covered by the insurance.

I also authorize the release of any medical information necessary to process insurance claims. A copy of the authorization shall be valid as the original. It is solely the responsibility of the patient to obtain a referral if insurance requires one to be seen by a specialist. The referral must be obtained prior to being seen. If the patient presents without a referral for treatment of any kind, payment for that date of service will be due from the patient or the appointment will be rescheduled. There will be a $32.00 charge on all returned checks. Co-pays are expected at the time of service. I accept that referrals are my responsibility to obtain from my primary care physician if needed. I accept that services not approved by my insurance are my responsibility. All appointments that are not cancelled at least 24 hours in advance of my appointment may result in a $25.00 no-show fee or dismissal from the practice. If I arrive more than 15 minutes late for my appointment, I may be asked to reschedule.

In accordance with HIPAA, I have had the opportunity to read and review a copy of the privacy practices in the offices of Comprehensive Foot and Ankle Centers.

I understand that honest and complete answers to every question are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the forms, I should ask the doctor or a member of the staff for assistance.

NOTE: ORIGINAL X-RAYS ARE THE PROPERTY OF THIS OFFICE. DIGITAL COPIES ON DISCS MAY BE PURCHASED FOR $5.00 EACH.

Patient (or person authorized to consent for patient) Signature:_____________________________________
Relationship to Patient (if not self): __________________________________Date:_______________________