

# DeLand Foot and Leg Center, LLC.

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

**WE ARE PLEASED TO OFFER OUR PATIENTS ELECTRONIC BILLING.**

**If you would like to have your Statements and Appointment Reminders sent electronically.**

**Please list your email address:** \_\_\_\_\_

Who referred (physician, attorney, or employer) you to DeLand Foot and Leg Center, LLC? \_\_\_\_\_

Emergency Contact Information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIFETIME SIGNATURE AUTHORIZATION AND INSURANCE PAYMENT ORDER (REQUIRED) and  
Acknowledge of Receipt of Notice of Privacy Practices**

- I authorize the release of my medical information necessary to process my claims. I also authorize any request of payment of medical benefits to DeLand Foot and Leg Center, LLC or treating physician.
- I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Please be advised that the following forms are available upon your request:

- Patient Authorization of Release Health Information
- Patient Complaint Form
- Accounting of Disclosures Form
- Request for Correction/Amendment of Health Information
- Restriction Request Form
- Request for Confidential Communication

**Everything I have answered is true, complete, and correct to the best of my knowledge.**

\_\_\_\_\_  
Patient or Guardian's Signature / Date

THANK YOU FOR COMPLETING THIS FORM.  
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD  
AT DELAND FOOT AND LEG CENTER, LLC.