Dr. William Grant
FOOT & ANKLE

HEALTH INSURANCE INFORMATION

Primary:
Insurance_____ ID#_____ Group #_____

Policy Holder's Name, if not the patient _____

DOB _____ SS# _____

Relationship to Patient _____

Secondary:
Insurance _____ ID#_____ Group#_____

Policy Holder's Name, if not the patient _____

DOB _____ SS# _____

Relationship to Patient _____

WHEN THERE ARE CHANGES TO YOUR INSURANCE COVERAGE/PERSONAL INFORMATION OR MEDICAL HISTORY, PLEASE NOTIFY OUR OFFICE.

We welcome you to the office of Dr. William P. Grant, Diabetic Specialist, and assure you that we will provide you the best care possible. This information is intended to provide clarification and prevent future misunderstanding. We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. Please remember that insurance benefits are based on a contract between you and your insurance company and you are responsible for your account balance should your insurance company deny any payment. All co-pays are due at each visit prior to treatment. Your appointment may be rescheduled if this is not achieved. Nonpayment on your account can result in termination of services and referral to another provider. If your account is referred to collection, you will be responsible for costs in the amount of 30% of your outstanding balance, together with court costs and attorney's fees. Checks that are returned to the office are subject to a $35 bank processing fee.

By signing below, I certify that I consent to treatment at Dr. William Grant's office and have read and understand the office policies.

_____ _____
Patient/Responsible Party Signature Date