Patient Information:

Last Name: _______________________ First Name: _______________________ MI: ________

Home Address: ____

City: _________________________________ State: ___________________ Zip: ____________

Home Phone: __________________________ Cell Phone: _______________________________

DOB: __________________ AGE: _______ Single/Married/Divorced/Widow: ______________

Social Security #: ________________________

Employer: __________________________________ Work Phone: ________________________

FT/PT/Retired: _________________ E-mail: ____

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Primary Care Doctor: ______________________________ Phone: ________________________

Emergency Contact: _______________________________ Phone: ________________________

Pharmacy: ____ Phone: ________________________

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If insurance isn't in your name:

Card Holder's Name: ____________________ Relationship: _________ DOB: ___________

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If worker's comp. please complete:

Date of Injury: _________________________ Claim Number: _______________________

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If Primary is Medicare, please complete:

Are you covered under a group policy? Y or N

Are your injuries accident related? Y or N If yes, date of injury: _______________________________

Who is responsible for your bill: ____

Is your spouse employed? Y or N Do you have a secondary insurance? Y or N

Have you ever served in the military? Y or N Do you have a Medicare Advantage Plan? Y or N

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I have read all the information on this sheet and have completed the above answers to the best of my ability and certify the information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information. I further, hereby authorize this office through its appropriate personnel to furnish medical treatment to me, or the above named patient, considered necessary and proper in diagnosing and treating my/his/her medical condition.

Signature: ____ Date: ____________

Guardian or POA, if not patient: ____

Assignment of Benefits Form
Dr. Tim Levar, D.P.M.
34600 Chardon Rd, Suite 9
Willoughby Hills, OH 44094

I, (your name) ___________________________, (DOB) ____________, understand that services rendered to me by, Dr. Tim Levar, are my financial responsibility and that the provider will bill my insurance company, (Insurance company name) __________________, as a courtesy. I authorize my insurance company to pay my benefits directly to Dr. Tim Levar and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional charges over and above the insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing the information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Dr. Tim Levar within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event I receive any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to the provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with the provider and bring any balance owed by me to the provider immediately due and payable.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in resolution of claims delay or unjustified reductions or denials.

Date: _________ Patient/Guardian Signature: ______________________________________

Policy holder if NOT the patient: ____