

INSURANCE INFORMATION

(A copy of your insurance card is also required)

PRIMARY COMPANY: _____

SUBSCRIBER #: _____ GROUP/PLAN#: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

SUBSCRIBER'S RELATIONSHIP TO INSURED: () Self () Spouse () Child () Other

SECONDARY COMPANY: _____

SUBSCRIBER #: _____ GROUP/PLAN#: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

SUBSCRIBER'S RELATIONSHIP TO INSURED: () Self () Spouse () Child () Other

**Silicon Valley Podiatry Group
2512 Samaritan Ct. Suite A
San Jose, CA 95124**

THE FOLLOWING OUTLINES OUR PATIENT RESPONSIBILITY POLICY:

Please provide Silicon Valley Podiatry Group with updated and accurate insurance information. If you do not have your insurance card or information, then payment is due at the time of the visit.

In order to be compliant with insurance companies you must pay your Co-Pay at the time of your visit.

While we assist you with billing your insurance company, you are primarily responsible for determining what your insurance will cover, whether you require an authorization, and payment of the bill.

Your insurance payment should be made to Silicon Valley Podiatry Group for all services rendered. Patient authorizes release of information, as necessary to satisfy submitted claims, by the above named medical office to your insurance.

There is a 4-page copy of our Notice of Privacy Practices, which provides a detailed description of what we do with health and personal information that we have about you. It also explains your rights, as a patient, for getting access to that information and controlling its use and disclosure. You may sit in our office and review this information. A copy of Silicon Valley Podiatry Group Notice of Privacy is available upon request.

Signature (Responsible Party)

Date