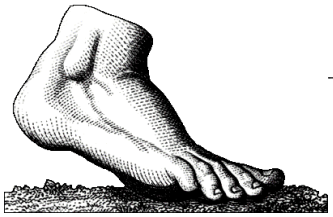


BAY AREA FOOT & ANKLE ASSOCIATES

JOHN W. SCIVALLY, D.P.M., F.A.C.F.A.S.
BYRON CARRASCO, D.P.M.

WELCOME

PATIENT INFO:

First Name: _____ M.I. ____ Last Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Hm Ph: _(____)_____Wk Ph _(____)_____

Age: _____ D.O.B.: _____/_____/_____ Sex: M F SSN: _____-_____-_____

Driver's License: _____ State: _____ Spouse's Name: _____

Referred by: _____ Primary Physician: _____

Is your visit today a Worker's Comp Claim: Y N Auto Accident: Y N

Best number to reach you to inform you of lab results, appt. changes, etc?

Hm # Wk # Cell #: (____)_____

EMPLOYMENT INFO:

Occupation: _____ Employer: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _(____)_____

EMERGENCY INFO:

Name of person to contact: _____Ph: _(____)_____

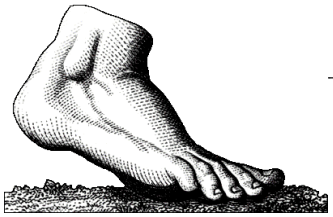
Address:_____City:_____ State:____

Zip: _____ Relation: _____ Wk Ph: _(____)_____

130 La Casa Via #1-204
Walnut Creek, CA 94598
(925) 937-2860

2227 Olympic Blvd.
Walnut Creek, CA 94595
(925) 932-3663

2400 Balfour Road #230
Brentwood, CA 94513
(925) 937-2860



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BYRON CARRASCO, D.P.M.

IMPORTANT INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate or suspend my care and treatment, all fees for professional services rendered me will be due and payable immediately. In the event of default, I promise to pay legal interest on the indebtedness together with any such collection costs and reasonable attorney fees that may be required to effect collection of the balance due. Payment for services rendered and/or co-payment are due at time of service unless special arrangements are made with the billing department. Any payment and/or co-payment not received at time of service will be assessed a $10.00 service charge. For any credit card transaction of $15.00 or less, there will be a $2.00 service charge.
There are thousands of insurance plans and the companies are constantly changing their coverage. It is your responsibility to know exactly what procedures, visits, medications and labs your plan covers. Read your insurance information carefully and call the company if you have any questions. Any time that you have a change of your mailing address or insurance, you must inform this office so that we can update your chart. If we must re-bill because of incorrect insurance and/or address information, there will be a $10.00 service charge. We accept you as a patient with the understanding that you know your coverage and benefits. In the event that your insurance denies a claim, payment for that/those date(s) of service is/are due immediately upon receipt of a statement. I authorize Dr. John W. Scivally and/or Byron Carrasco, D.P.M. to release any information required to process my claim(s). I also authorize the release of my records to other medical professionals for the purpose of treatment. Dr. John W. Scivally and Dr. Byron Carrasco agree to accept the charge determination of the insurance carrier as the full charge and the patient is responsible only for the deductible, co-insurance, co-payment and any non-covered services. Co-payments, co-insurance and deductibles are based upon the charge determination of the insurance carrier.

- ***I have read and agree with the above financial disclosures and hereby authorize Dr. Scivally and/or Dr. Carrasco to examine and treat me and/or my minor child as deemed necessary.***

PATIENT'S SIGNATURE:X_____DATE / /

GUARDIAN'S SIGNATURE:X_____

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