Lorna C. Wolfe, D.P.M., P.A.
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Frederick, MD 21702
301-695-9527
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Patient Name: First Middle Last _____ Date of Birth _____ Age _____ Sex M/F _

Home Address: Street City State Zip _____ Marital Status S/M/D/W

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security Number _____ Email Address _____

Employer _____ Occupation _____

Primary Insurance _____ Name of Policy Holder _____ Policy Holders Date of Birth _____

Secondary Insurance _____ Name of Policy Holder _____ Policy Holders Date of Birth _____

Chief Complaint _____

Referred By_____ Primary Doctor_____

Preferred Pharmacy_____

Financial Policy

1. Payment for non-insurance covered services and co-pays is expected at the time of service. 2. As a courtesy to the patient, fees will be submitted to the insurance companies first. The insurance company may allow us to bill you for the balance. Payment for services provided for patients with an insurance company that we do not participate with, is expected at the time of service. All balances will be your responsibility after 30 days. Payments past due over 90 days will incur a 6% collection fee.
3. For laboratory fees on orthotics, 50% of the fee is due at the time of casting and the balance upon receiving the appliances.
4. A copy of your records is $17.80 Plus 60 cents per page. There will be a charge of $10.00 for any and all forms that are filled out. A "No Show" visit and less than 48 hours' notice will result in a charge of $35. Checks return will result in a charge of $25

I have read and understand this policy. I give permission to Dr. Lorna Wolfe to examine and treat me.

_____

Signature Date

EMERGENCY CONTACT AND PHONE NUMBER: _____