THE FOOT CLINIC
DISEASES AND SURGERY OF THE FOOT & ANKLE
FRANK WILLIAM ZAPPA, DPM

Insurance Information

INSURANCE COVERAGE

Check One:

☐ **HMO** ☐ **PPO** ☐ **EMPLOYER PLAN** ☐ **MEDICARE** ☐ **OTHER**

Name Date

Name of Company

Address

City State Zip

Phone Number Plan Group Number

ID Number or Medicare Number

Insured Name Relationship to Patient

SIGNATURE

I authorize the release of any medical information necessary to process claims to my insurance company(s). And where applicable payment of medical benefit to Dr. F. W. Zappa.

I understand that any charges incurred that may not be covered by my insurance policy are my responsibility.

Signature of Patient or Authorized Person Date