



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